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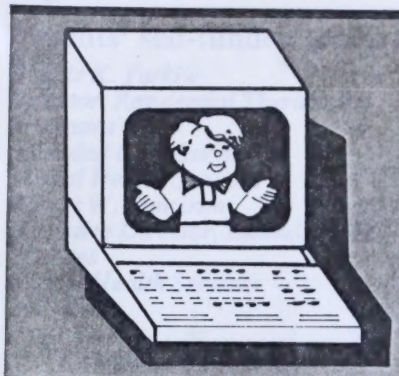

RESEARCH & INFORMATION

MENTAL HEALTH & CHILD WELFARE NEWSLETTER

Innovative programs for the chronically mentally ill

Pharmaceutical repackaging of drugs by vocational rehabilitation personnel of Claresholm Care Centre

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Claresholm Care Centre
Sharon Brown
Community Employment Supervisor
Occupational Therapy Department
Claresholm Care Centre
168-1302

A proposal has been submitted to the provincial government concerning the possibility of Claresholm Care Centre residents repackaging medication. The repackaging will be done in conjunction with the Pharmacy department and under the direct supervision of an Occupational Therapy Assistant. The program will employ 8 to 12 Care Centre residents and/or Day Care clients. Ultimate control and responsibility of the operation will be the province of the pharmacist (and/or the Clinical Director) of the Care Centre.

The mandate of the Care Centre has recently changed to include vocational rehabilitative functions. Public attitudes toward mental illness have become more enlightened and gainful employment has become possible in occupations previously unattainable to psycho-socially handicapped adults. Vocational training is essential if residents of the Centre are to be competitive in a labor-surplus market. The nature of the repackaging operation will make it possible for residents to enter the program at a low skill requirement level and progress through stations until maximum skill level has been achieved. Upon completion of the program residents will be qualified to compete for repackaging positions at places such as Fanning Centre or Calgary General Hospital — facilities currently engaged in on–site packaging.

Residents participating in the program will benefit from the practical training aspects of the job and will also receive positive reinforcement to enhance their self–esteem. It will be emphasized that repackaging is an essential service and residents selected for the program will hold positions of great responsibility and trust. The different skills required for each station will allow residents to see the progress they have made. Additional responsibility will accompany graduation to each successive station. Mastery of the station requirements will enable residents to feel "job competent" and better equipped to face competition and job pressures upon discharge from the Centre. Provision will be made for residents to remain in the program should discharge to the community not be immediately feasible.

Control of medication and resident safety has been a primary objective in the establishment of policy and procedure for the pharmaceutical repackaging workshop. Extensive measures will be introduced to ensure that repackaging will be the highest calibre and that any unusual occurrences will be handled by following the procedures outlines in the proposal. Security of the building, residents and staff has also been carefully considered and is presented in detail in the proposal.

Western Industrial Research and Training Centre, Edmonton, has been repackaging medicine into blister packages for over three years. Their record for quality control is impeccable and their contractor, University Hospital, is considering employing some of their clients on–site to do stat orders. It is entirely conceivable that the Claresholm Care Centre repackaging workshop could expand to include contractual work for many hospitals in Southern Alberta. Copies of the proposal, or additional information about the program may be obtained by contacting me at the Care Centre.

NOTE!! Due to structural changes currently being undertaken at the Care Centre the pharmaceutical repackaging operation has been placed on hold. Functional planning at the Centre will hopefully include provision in Pharmacy for space to include this program.

Introduction

The Research and Information Newsletter is published by the Mental Health/Child Welfare Research Unit in order to make it possible for Departmental individuals and groups to keep abreast of current research and information related to Mental Health, Child Welfare, and other Departmental programmes. The Newsletter will present abstracts or summaries of selected relevant articles or papers produced by Departmental Staff. These will include new projects, published and unpublished papers, conference presentations, as well as research news.

If you feel you have an article which you think should be included in an issue of the Newsletter, please submit a summary of your work (maximum 1000 words).

Patients' self-funded group house

Dennis K. Yurkiw
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Extended Care Services
Mental Health Services
Robert W. Cameron
Executive Director, Extended Care Services
Mental Health Services
297-4545

The challenge met by institutionalized patients was to secure supportive permanent housing in the community of Raymond, Alberta.

Objectives dictated by the prospective tenants included: a bed by the window, no direct government handouts, walking distance to the institution, and a permanent arrangement. A supportive environment was essential to reintegrate these people into the community.

We found the essential ingredients of a permanent community housing option for long–term patients are: A non–profit corporation to act as the vehicle through which housing can be rented, purchased or constructed; a board of directors consisting of elected lay persons and patients; a group of persons able and willing to live together and willing to pool their skills and funds; an available therapeutic and day activity program; and a pool of potential persons able and willing to move from the institution.

Six ladies were discharged in October of 1983 and have moved into the newly constructed six bedroom house. Since this has been a success, both therapeutically and financially, and a credit to the general community, the society, again through subsidized mortgage, will begin construction of its second six bedroom house in October, 1985.

Innovative community mental health programs

Adoption reunions: An emotional triangle

Raymond Ensminger
Clinical Social Worker/Mental Health Therapist
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I feel that mental health professionals have not adequately understood nor addressed major issues for members of the adoption community (birth parents, adoptive parents and adoptees). Adoption in the western world is a social institution fraught with myths and misunderstandings. Two major myths are: 1) that adoption is a time limited process, and 2) that having children by adoption is no different (or alternately, that it is totally different) than having children by birth. Much professional practice has been based on these myths.

One current issue for adoptees is the right to obtain more information about their birth origins which often leads to search and reunion with birth parents. Curiosity and the need to know more about one's origins can hardly be considered abnormal.

I can appreciate the concerns of adoptive parents that they don't want to be "temporary and second–best". I certainly agree that adoptive parents are real parents; however, that does not negate the fact that adoptees have another set of parents. In an adoption, if a strong parent–child relationship is established and then maintained into adulthood, an adoptee's search for and reunion with birth parents will not disrupt that relationship.

In fact, research indicates very clearly that adoptee's relationships often are confirmed and strengthened as a result of a reunion because the adoptee realizes that the real psychological parents are the adoptive parents. (That does not preclude the possibility of an ongoing relationship with the birth parents.) In other words, being a parent is primarily a caring, nurturing process which may include a biological function.

An equally important part of the issue is the birth parents. A fairly common myth exists that conceiving, giving birth and surrendering a child completes the process. That is not the case. Adoption is a life–long process. Many birth parents (especially mothers) continue to have questions, concerns and hopes regarding the child. Sometimes these concerns are finally resolved with reunion.

The jury is still out regarding the ideal adoption process. If we as professionals clearly understand the process (especially from the experiences of the participants) we may even play a role in the development of that process.

The "Rotten Choice" support and study group

Elizabeth M. Grintals
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Mental Health Services, Lethbridge

Jennifer Butterfield
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There are always people who seem to go from one poor relationship to another or to have relationships that are disastrous for themselves and their families. The results may mean physical, emotional and sexual abuse, poverty, depression and life–threatening situations. But in spite of past experiences, the pattern would be repeated in the succeeding relationship. Because we met a number of such people in our work at Alberta Mental Health Services — clients coming in for personal problems or because of difficulties with children, we decided in the spring, 1984, to organize "The Rotten Choice Study Group" for the purpose of looking into this whole area with the clients themselves.

The group is still going strong, though with some changes in focus and membership. It is an open group, meeting weekly, with breaks coinciding with school holidays. Besides discussion arising out of personal crisis of members, we have used a variety of instruments to promote group awareness: self–questionnaires, articles

"Rotten Choice," continued from page 2

from current and popular journals and books, guest speakers. We have gained some insights into the background and beliefs of the members. They expressed interesting and significant attitudes to sex, marriage and the preferred marital state, parent–child relationships, loneliness, name–calling, and personal violence.

We see evidence of growth with the group. Some tangible signs of change include members increasing ability to analyze past relationships, the recognition of the need to change, some attention to the other side (the man's side) of the "rotten choice", and real support to each other outside sessions.

We have had to argue for this group being an appropriate program of Mental Health Services. The reality is that the vast majority of members already had Clinic involvement for personal and family problems, and several with lengthy histories of even two and three generations. What the group has been able to do is to engage women in a therapy program of some length, where, often for the first time, in spite of numerous previous Clinic contacts, they actively consider their personal histories and difficulties. Instead of dealing with just the immediate crisis, or of identifying the problem with their children, they are looking at their particular needs which have been significant in the extended family problem.

Recent projects approved by AMHS Research and Ethics Review

1. Neuropsychological Correlates of Emotional and Academic Problems.
   N. Brodie
   Edmonton Region
   427-4444

2. Clinical Evaluation of Reconciliation Counselling with Families of Incest.
   N. Case
   Edmonton Region
   427-4444

3. Needs Forum on Counselling Native Families.
   N. Case
   Edmonton Region
   427-4444

4. Completed Suicides and Their Involvement with AMHS and Child Welfare.
   R.J. Dyck
   S. Jetha
   Head Office
   427-2816

5. Social Adjustment and Client Satisfaction on Longer Term Patients in the Community.
   G. Ekisa
   Edmonton Region
   427-4444

6. Adolescent Parasuicide Behavior and Its Relationship to Family Dynamics.
   J. Eliuk
   Edmonton Region
   427-4444

7. Needs of the Chronically Mentally Ill.
   L. Gardner
   C. Roberts
   K. Radchuck
   Head Office
   427-2816

8. Analysis of Effectiveness of AMHS from the Perspective of Stakeholders Reports.
   C. Gregor
   Edmonton Region
   427-4444

9. A Study of Client Satisfaction with AMHS (Edmonton Region).
   M. Provencher
   J. Eustace
   V. Smith
   S. Key
   Edmonton Region
   427-4444

Recent publications by departmental staff

1. Bland, R.C., *Long Term Mental Illness in Canada: An Epidemiological Perspective on Schizophrenia and Affective Disorders.* Canadian Journal of Psychiatry, Vol. 29, April 1984.
Head Office 427-2816

2. Brazier, B., MacDonald, L., *Should Job Satisfaction Surveys Be Signed.* Journal of Practical Approaches to Developmental Handicap, 8 (2), 1984.
Edmonton Region 427-2065

3. Ensminger, R.O., *Adoption Reunions — An Emotional Triangle: Some Background.* The Social Worker, 52 (2), Summer, 1984.
Edmonton 963-6151

4. Ensminger, R.O., *Pioneer For Adoption Reform.* Exchange, An Adoption Research Project Publication, 2 (4), 1984.
Edmonton 963-6151

5. Gaunce, R.J., Pettifor, J.L., *Primary Prevention and Mental Health Promotion: The Alberta Experience.* (Chapter) in Lunsden, D.P., (Ed.), Community Mental Health, Action, Ottawa C.P.H.A., 1984.
Edmonton 427-3365

6.Barnsley, R.H., Thompson, A.H., Barnsley, P.E., *Hockey Success and Birthdate: The Relative Age Effect.* Canadian Association for Health, Physical Education, and Recreation Journal, 18 (1), 1985.
Head Office 427-2816

"Rotten Choice," continued from page 2

Recent projects approved by AMHS Research and Ethics Review

Recent publications by departmental staff

7. Barnsley, R.H., Thompson, A.H., *Gifted or Learning Disabled? The Age of Entering School May Make the Difference.* Early Childhood Education Journal, 18 (1), 1985.
Head Office 427-2816

8. Bland, R.C., Brintell, S., *Electroconvulsive Therapy in a Major Teaching Hospital: Diagnosis and Indications.* Canadian Journal of Psychiatry, Vol. 30, pp 288-91, June, 1985.
Head Office 427-2816.

9. Thompson, A.H., *Psychoticism and Signalled Versus Unsignalled Reaction Time.* Personality and Individual Differences, Vol. 6, No. 6, pp 775-778, 1985.
Head Office 427-2816

10. Cameron, R.W., Yurkiw, D.K., Little, B.D., *Self–Funded Group Home for Former Long–Term Residents of a Mental Health Facility.* Canada's Mental Health, Vol. 33, No. 3, pp 32-33, September, 1985.
Extended Care Services 297-4545

11. Thompson, A.H., *A Test of the Distraction Explanation of Disfluency Modification in Stuttering.* Journal of Fluency Disorders, Vol. 10, pp 35-50, 1985.
Head Office 427-2816

12. Al–Issa, B.H., *Skid Row Services — Do They Meet Clients Needs?* (Chapter) in M.R. Rodway, (Ed.), The Teaching of Social Work Methods, Dimensions and Innovations, Calgary: Faculty of Social Welfare, University of Calgary, 1986.
Fort McMurray 136-7450

General news

RESEARCH GRANTS

Recipients of Research on Aging Grants, 1985-86

1. Faculty of Home Economics, The University of Alberta.
"A Study of Taste Perception and Dietary Intake of Elderly Albertans"
Margaret I. Gee/Zenia J. Hawrysh.

2. Department of Family Studies, The University of Alberta.
"Effects of Vicarious Experience and Learning Materials on the Metamemory and Cognitive Performance of Senior Adults and Adolescents"
Nancy L. Hurlbut

3. Department of Family Studies, The University of Alberta
"Factors Which May Predict the Institutionalization of Alzheimer's Patients"
Norah Keating Ph.D./Sharon Warren Ph.D.

4. Department of Educational Policy and Administrative Studies, The University of Calgary.
"Support System and Adjustment Problems of Aging Persons of South Asian Origin in Calgary"
M. Zachariah

5. The School of Nursing, The University of Lethbridge.
"The Validation of Dance and Exercise Therapy in the Elderly"
Christopher A. Armstrong-Esther/Freda Myco/Mark Sandilands

6. The Department of Sociology, Athabasca University.
"A Study of Volunteers Using the Facts on Aging Quiz"
Dr. John R. Minnis

RESEARCH & INFORMATION
MENTAL HEALTH & CHILD WELFARE NEWSLETTER

is published quarterly by Mental Health/Child Welfare Research Unit and distributed to departmental employees interested in research issues and related information.
Editor: Deanna Fuhr

If you require additional copies of the newsletter, or know of any individual or group that would like to receive future issues, please telephone Deanna Fuhr at 427-2816, Edmonton or write to Mental Health/Child Welfare Research Unit, 4th Floor, Seventh Street Plaza, 10030 - 107 Street, Edmonton, Alberta, T5J 3E4.

Alberta
SOCIAL SERVICES AND COMMUNITY HEALTH
COMMUNITY HEALTH DIVISION

RESEARCH & INFORMATION
MENTAL HEALTH & CHILD WELFARE
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SOCIAL SERVICES
AND COMMUNITY HEALTH
COMMUNITY HEALTH DIVISION

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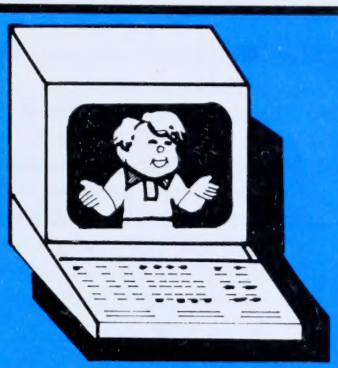

RESEARCH & INFORMATION

MENTAL HEALTH & CHILD WELFARE NEWSLETTER

Epidemiology of psychiatric disorders in Edmonton: Some clinical and program implications

Overview

The following four papers will be presented as a symposium at the annual conference of the Canadian Psychiatric Association in Vancouver in September, 1986.

The four papers derive from the same research and thus have similar methodology.

Randomly selected adult household residents of Edmonton were interviewed by trained lay interviewers using the Diagnostic Interview Schedule (DIS) (an instrument designed to yield DSM III diagnoses) and the General Health Questionnaire (GHQ) (a rapid screening test for non-psychotic psychiatric disorders). DIS data was analysed using the Washington University program. Interviewing commenced in 1983 and is still continuing. Over 3000 interviews have been conducted thus far.

Diagnoses from the DIS may be given as lifetime (has the person ever had the disorder), or for specified time intervals, e.g. the month prior to interview. They may also be generated using the DSM III hierarchies (exclusions) or hierarchy free. The symposium papers use various combinations of these.

The papers were prepared at various stages of data collection and therefore use different sample sizes. All were selected for their relevance to service delivery or clinical practice.

The paper by Newman et al. examines the results of a rapid screening test for psychiatric disorders (GHQ) when compared with a detailed diagnostic interview (DIS), and suggest that only for depression is the GHQ an adequate screen. Dyck et al. present the population rates for attempted suicide and then compares the psychiatric disorders in those who attempt suicide to the remainder of the population. Bland et al. examines the unemployed and finds rates for psychiatric disorders to be much higher in the unemployed than in the employed, findings with clear implications for service organizations. Thompson et al. uses the data to examine the relationships between phobias and depression and discusses the clinical implications.

Introduction

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If you feel you have an article which you think should be included in an issue of the Newsletter, please submit a summary of your work (maximum 1000 words).

Relationship and course of depression, agoraphobia and panic disorder in the general population

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H.E. Orn
Research Officer

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There are numerous indicators in the literature that depression is strongly associated with the anxiety disorders of agoraphobia and panic disorder, with panic disorder being viewed as a near essential component of agoraphobia. Theory suggests that depression is primary, serving as the substrate for anxiety disorders in general. The inter-relationships between the three disorders was examined by analysis of the results of a survey of 2200 individuals from randomly selected households in Edmonton. The

continued on page 2

Relationship and course, continued from page 1

instrument used was the Diagnostic Interview Schedule, (DIS) which provided lifetime DSM-III diagnosis of major depression, agoraphobia and panic disorder.

Examination of the odds ratios and lifetime prevalence figures for each of the three disorders in isolation and in combination confirmed the strong association between depression and the two anxiety disorders. However, the expected strong relationship between agoraphobia and panic disorder was not observed. A minority of agoraphobics showed evidence of panic disorder, and nearly all that did had also suffered major depression. In regard to age of onset, first symptoms of agoraphobia appeared much earlier than those of depression for those subjects who had experienced both disorders (approximately 5 years difference). Panic disorder appeared at about the same mean age as depression.

The tendency for phobic symptoms to be precursors of depression does not support the theoretical view that depression is the substrate for anxiety disorders. One must also question the hypothesis that panic disorder is an integral component of agoraphobia as this association was not supported in the present study.

Implications of the results of this study are (1) a need for more epidemiological studies on the inter-relationship of these disorders (2) alternative theories need to be developed (eg. anxiety may play a causative role in depression) (3) for the clinician increased awareness that child or adolescent cases with phobias are at high risk for depression, and (4) given the retrospective nature of instruments like the DIS, more research is needed on the validity of long-term recall of psychiatric symptomatology.

Suicide attempt and psychiatric disorder

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Greater emphasis has been given recently to identifying and describing those who deliberately harm themselves. In part, this is a result of the increase in the rate of suicide attempts both in Western Europe (Diekstra, 1981) and in North America (Weissman, 1974). Although the ability to predict who will deliberately engage in suicidal behavior has not improved greatly (Pokorny, 1983), Murphy (1983) has argued that clinical descriptive studies of suicide attempters do provide clinicians with important and useful information that may assist in the identification of at risk persons. With this information, appropriate clinical interventions can be implemented. The purpose of the present study was to delineate further the relationship between suicide attempts and various psychiatric disorders and social problems by means of a standardized and reliable interview method, the Diagnostic Interview Schedule (DIS).

The results reported here are based on the first two thousand, two hundred interviews conducted in a study of the prevalence of psychiatric illness in the city of Edmonton, Alberta. Respondents were selected from a randomly generated set of residential addresses. As only one individual in each household was to be interviewed, a household respondent selection key (Backstrom and Hursh-Cesar, 1981) was used.

Of the two thousand, two hundred respondents, one hundred and six (4.8%) stated that they had attempted suicide at sometime in their lives (6.2% of females and 2.9% of males). Male attempters tended to be aged 25-44 years and divorced or never married, whereas, female attempters tended to be over-represented in the age categories of 18-24 and 25-44 years and single (never married, separated, divorced).

Examining the relationship between suicide attempts and psychiatric disorders, it was found that 11.3% of those who had a diagnosable disorder at some time in their life and also attempted suicide; almost all males (92.3%) and over three-quarters of the females (77.5%) who attempted suicide also had suffered from some psychiatric illness at some time in their life. Specifically, such disorders as schizophrenia/schizophreniform, affective disorders, major depression and recurrent depression were significantly related to suicide attempts. In addition to finding family and other violence related to suicide attempts, unemployment was found to be related as well. These findings are discussed in terms of their implications for the assessment and treatment of the suicidal patient.

Screening for psychiatric disorder with the general health questionnaire

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The General Health Questionnaire (GHQ, 30 item version), a brief self-administered screening test for recent nonpsychotic psychiatric illness, and the Diagnostic Interview Schedule (DIS), a structured interview designed to make DSMIII diagnoses, were completed on 2144 randomly selected adult residents of Edmonton. The GHQ, scored by the 0011 method, was assessed as a screening instrument against all DIS-DSMIII diagnoses present in the month preceding interview. With GHQ scores dichotomized into low and high categories by cutting at 4/5, the power of the GHW as a screening test was assessed. Of those subjects found to have a DIS-DSMIII diagnosis, 82% (specificity) had a low score. When individuals DIS-DSMIII diagnoses were

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Screening for psychiatric disorder, continued from page 2

similarly assessed, only depression showed a substantially improved sensitivity (88%), specificities remaining largely unchanged. Multivariate statistical analysis based on the logistic regression model demonstrated that the probability of being a DIS-DSMIII case depended on age, marital status and GHQ score, but not sex. With GHQ score treated as a continuous variate, it was found that as GHQ score increased so did the chances of being a case. These findings suggest that in the community setting the GHQ is not highly sensitive over the range of DIS-DSMIII diagnoses, but that subjects with a high GHQ score are likely to have a recent psychiatric disorder.

Psychiatric disorders and unemployment in Edmonton

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G. Stebelsky
Research Co-ordinator

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Research Officer

S. Newman
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Significant relationships were found between unemployment in the last five years and a lifetime history of psychiatric disorder. These results are based on interviews of 2000 randomly selected adult household residents of Edmonton, conducted by trained lay interviewers using the Diagnostic Interview Schedule (DIS) and the General Health Questionnaire (GHQ). Having a lifetime history of psychiatric disorder increased the odds of being unemployed by 3.4 times, and 64% of the unemployed had had a psychiatric disorder. Disorders carrying the highest risk for unemployment were antisocial personality disorder. Of the unemployed 37.7% had had alcohol abuse/dependence, 16.9% major depression and 14.8% antisocial personality disorder. Based on the GHQ the unemployed, particularly in the 45-64 age group had higher current symptom levels than the employed.

Behavioral services

Behavioral parent training by telephone

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Director
Community Behavioral Services

Barry Brazier
Community Outreach Supervisor

Community Behavioral Services
427-2065

Presented at A.A.B.T. Convention
Houston, Texas, November, 1985.

Parent training is typically provided through personal instruction to small groups of parents or individually on a weekly basis, and generally supplemented with a manual, role-plays, video tapes, and handouts (O'Dell, S., Flynn, J., and Benlolo, L., 1977; Matson and Ollendick, 1977). Unfortunately, in rural areas where clients live many miles from the nearest service provider, this format is not feasible simply because of the travel time involved.

One possible alternative is training parents by telephone in conjunction with a self-help manual. There is some evidence that this approach may be successful in teaching parents how to develop self-help skills in their retarded children; however, it is questionable whether a telephone consultation and self-help-manual approach can be used to teach parents how to manage the behavior problems of their children (Baker & Heifetz, 1976). Other research suggests that therapist feedback may be important in parent training although the extent to which such involvement is necessary is still unclear (Horton, 1982).

The present study was conducted to determine the effectiveness of providing behavior-management training by telephone to parents in rural areas. Outcome data was compared with that obtained from city-based parents participating in a standard group workshop with weekly home visits by the therapist. Indicators of effectiveness included behavioral program data, behavioral knowledge before and after training, parent satisfaction feedback, relative amounts of contact time, and attrition rate.

A comparison of 10 telephone-trained parents and 36 workshop-trained parents indicated no difference in parent's success rates, knowledge acquired, or satisfaction with the mode of training. However, the amount of time spent in direct contact with the parents was considerably less with the telephone format. With adequate attention to ethical concerns, telephone training in rural areas is not only program-effective but cost-effective, and needs to receive greater attention by researchers in the area of parent-training.

Suicide

Suicide in Canada: An examination of the trends

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Epidemiologist

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Presented at the Sixth Annual Symposium; Suicide Research in Alberta. Calgary, May, 1984.

The increasing rate of suicide is a growing concern to Mental Health Professionals, government and the public. In Canada, not only have suicide deaths increased relative to the proportion of all deaths (Labovitz and Brinkerhoff, 1974), but the actual suicide rates have also increased (Sakinofsky, Roberts and Van Houten, 1975; Newman, 1984). While previous research has focused on comparing rates across different time period, (Diekstra, 1982; Sakinofsky et al, 1975; Jarvis, 1980) or examining rates in a particular location (Farmer, Preston, and O'Brien, 1977; Hellon and Solomon, 1980), little attention has been given to examining the variations of suicide rates over time for specific groups residing in different geographical regions. The purpose of the present study, therefore, is to examine Canadian suicide rates over a twenty-five year span as a function of age, sex, and geographical regions.

The results of this study are based on suicide and population data for each province and for the years 1955 to 1981 provided by Statistics Canada. The number of suicides over each of the three year period centered on the census year were averaged before computing rates. For the purposes of the analysis, Canada was divided into five regions: Atlantic, Quebec, Ontario, Prairies and B.C. Age-standardized suicide rates (based on the total population of Canada in 1981 over the age of fifteen years) were used for analysis. Data were analyzed using a multivariate statistical method, the Poisson Regression Model.

The analysis revealed that suicide among the fifteen to twenty-four year olds was increasing at a faster rate than in any other age group. However, it was noted that while the male rates for all ages except the fifty-five to sixty-four age group climbed steadily from 1956 to 1981, the female rate for all ages except the sixty-five plus group increased until 1971, plateaued until 1976, and then declined moderately. Regional differences in suicide rates were also apparent. Although not strictly observed, a trend toward increasing risk of suicide in males as one proceeds westward was found. For females, a pattern of increasing suicide with more westerly location was also found, except that Ontario and the Prairie provinces were in reverse order. The implications of these results for suicide prevention program planning and future research are discussed.

Community rehabilitation services

Chronic psychiatric patients in the community rehab service (AMHS) social adjustment and satisfaction – preliminary findings

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R.E. Welch
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Community Rehabilitation Services
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427-4444

From a pool of 857 long term psychiatric patients in the CRS, a random sample of 140 was contacted. Of these, 64 (45.7%) gave consent to participate in the study.

Results

1. **Demographic Data**

54.7% were males and 45.3% females. The mean age was 42.7 years (range 20-70). Schizophrenia, with male/female ratio of 3:1, comprised 53%. Over half (53%) had 5 or more hospital admissions and a further 23% had been admitted between 3-4 times (Table 2).

The majority of patients were single (65.6%) (Table 14). 78% were unemployed with only 15.6% being employed (full/part time) (Table 15). With regard to day time activities 18.8% attended vocational programmes and a further 12.5% were involved in some day programme but the bulk of the population (53%) were unoccupied (Table 16).

48.4% earned between $500-$699 per month, the main source of income being AISH/SAL (57.8%). Including those on OAP and those on part-time employment 73.5% are directly dependent on assistance.

For accommodation 40.6% lived in rented apartments, 9.4% had their own houses while 29.7% lived in approved homes. 29.1% had lived in their current accommodation for more than 3 years (Tables 19 and 20).

continued on page 5

Community Rehabilitation Services, continued from page 4

2. **Functional Status**

The results of the MAFI assessments (a measure of skills in personal routines, community living and social maturity) indicated that the bulk of the population scored in the intermediate range (ie, some skill deficits existed) especially in room and time management; leisure, budgeting and responsibility and in communication, getting and keeping friends and handling problems. The minority who exhibited severe inadequacies tended to be schizophrenics (Table 6).

There was no evidence of severe psychiatric symptomatology and those noted tended to be in the "mild" range. There was no correlation between the number of hospitalizations and symptom levels.

The population was found to have very low maladaptive behavior in the residential setting (Table 4).

3. **Social Adjustment**

The results of the SIS showed that using the "material conditions", "social management" and "satisfaction" scores as a measure of social adjustment, a significant majority of patients had adequate social adjustment (Table 5a). The only demographic data that correlated with social adjustment was age, ie, the older the patients, the more socially adjusted they were (Table 6a).

General Conclusion

This is a chronically disabled predominantly unemployed population dependent on social assistance for survival as well as on medical and psychiatric treatment for support. Their functional status is reasonably good and the majority show adequate social adjustment and are satisfied. They will require long term support and psychiatric follow up for life.

New findings and service priorities

Psychopathology of children in the care of child welfare

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Director of Research and Evaluation

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Presented at the Child Welfare League of America Conference, Group Care in North America, Houston, February, 1986.

Although there has been increased concern regarding the well-being of children in the care of Child Welfare, there has been minimal research on their mental health. The purpose of this study was to obtain an estimate of the proportion of Child Welfare children showing psychopathology and perhaps requiring Mental Health intervention.

Fifty Permanent and Temporary Wards from an Edmonton District Office of Social Services and Community Health were administered a number of psychological tests, which included measures of psychoticism, neuroticism, criminality, internalizing, externalizing, social competence, behavioral competence, depression, and self-esteem. Test cut-off scores were selected that would place 10% of the "normal" population in the psychopathological range. For example, 24% of the children were high on psychoticism in comparison to 10% in the normal population. Other factors showing statistically higher proportions were criminality (42%), internalizing (30%), externalizing (34%), social competence (56%) and behavioral competence (32%). Surprisingly, these children did not score higher than the normal population on neuroticism (16%), depression (12%), and self-esteem (8%). Overall, 82% scored in the psychopathological range on 1 or more tests, and 62% on 2 or more tests. Natives were over-represented in the sample, but showed no meaningful differences from non-Natives in psychopathology levels. The child's social worker's opinion on the presence or absence of psychopathology and need for mental health services indicated that 72% of the children were rated as displaying emotional disturbance, with forty per cent of the children recommended for counselling. The profile that appears for this group of subjects when one considers scores in the psychopathological range is a cause of some concern. That neuroticism, depression and self-esteem did not show abnormal distributions suggests that we are not dealing primarily with unhappy children who are responding to difficult life events. Rather, the over-representation of psychopathology on psychoticism, criminality and externalizing indicates that we appear to be looking at a personality pattern that could lead to serious adult disturbances that are difficult to treat. It is clear that the problems are severe, requiring extensive involvement with mental health professionals. Recognizing that the prediction of adult disorders is tenuous at best, the data nonetheless provide a strong suggestion that mental health intervention with disturbed wards may have preventative as well as immediate benefits.

Recent projects approved by Alberta Mental Health Services research and ethics review

1. Care Giving to Alsheimer Patients.
   Nora C. Keating
   Family Studies Department
   University of Alberta
   432-5771.

2. Education and Group Support for Families of Psycho-Geriatric Inpatients: An Evaluation of Two Approaches of Clinical Intervention.
   E. Galenza
   Rosehaven Care Center
   679-1411.

3. Psychopathology of Children in Mental Health Services.
   A.H. Thompson
   D. Fuhr
   Head Office
   427-2816

4. Young Offenders (Solicitor General) and Their Involvement with AMHS and Child Welfare.
   A.H. Thompson
   S. Jetha
   Head Office
   427-2816.

5. Child Welfare Case File Review.
   A.H. Thompson
   C. Rennie
   D. Fuhr
   Head Office
   427-2816.

6. A Prospective Study of the Mortality of Schizophrenic Patients in Alberta 1976-1985.
   S. Newman
   Head Office
   427-2816.

7. Child Welfare Staff Satisfaction.
   S.M. Heron
   Graduate Program
   University of Calgary

8. Leadership Behavior and Innovation.
   J. Morrison O'Hara
   Graduate Program
   University of Calgary.

9. Consumer and Therapist Evaluation of Service Delivery and Therapy Sessions in Mental Health.
   H. Neidermayer
   Clinical Director
   Corinne Gayton
   Research Assistant
   North West Region
   624-6151.

Recent publications by departmental staff

1. Blackman, M., Rauch, F., Pitcher, S., *A Preliminary Outcome Study of Community Group Treatment Program For Emotionally Disturbed Adolescents*. Canadian Journal of Psychiatry, Vol. 31, March, 1986.

2. Bland, R.C., Orn, H., *Psychiatric Disorders, Spouse Abuse and Child Abuse*. In Press, ACTA Psychiatrica Belgica, 1986.
   Head Office 427-2816.

3. Bland, R.C., Orn, H., *Family Violence and Psychiatric Disorder*. Canadian Journal of Psychiatry, Vol. 31, March 1986.
   Head Office 427-2816.

4. Cameron, R.W., Yurkiw, D.K., Flewelling, M. *Long Term Care Community Housing: A Practical Approach*. Quarterly - A Journal of Long Term Care, January, 1986, pp. 17-21.
   Extended Care Services
   297-4545.

5. Davies, Glyn. *Guardianship Alberta Style*. Discharge Planning Update, American Hospital Association, Winter, 1986.
   Office of the Public Guardian
   422-1868.

6. MacDonald, L., Barton, L.E. *Measuring Severity of Behavior: A Revision of the Adaptive Behavior Scale*. American Journal of Mental Deficiency, Vol. 90, No. 4, 1986, pp. 418-424.

7. Roth, M. *Problems of Runaway and Out-of-Control Adolescents in Residential Settings*. Alberta Psychology, Volume 14, No. 2, April 1985.

8. Vanderschaeg, E.L., *Child Abuse and Community Mental Health Practice*. Psychiatric Nursing, January, 1986, pp. 13-14.
   Youngstown Home
   779-3920.

RESEARCH & INFORMATION
MENTAL HEALTH & CHILD WELFARE NEWSLETTER
is published quarterly by Mental Health/Child Welfare Research Unit and distributed to departmental employees interested in research issues and related information.
Editor: Deanna Fuhr

If you require additional copies of the newsletter, or know of any individual or group that would like to receive future issues, please telephone Deanna Fuhr at 427-2816, Edmonton or write to Mental Health/Child Welfare Research Unit, 4th Floor, Seventh Street Plaza, 10030 - 107 Street, Edmonton, Alberta, T5J 3E4.

Alberta
COMMUNITY AND OCCUPATIONAL HEALTH

Volume 1 Number 3 Autumn 1986

RESEARCH & INFORMATION

MENTAL HEALTH & CHILD WELFARE NEWSLETTER

Psychiatric disorders

Psychiatric disorders, spouse abuse and child abuse

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Relationships between spouse abuse, child abuse and psychiatric disorders were examined using standardized psychiatric diagnostic interviews (The Diagnostic Interview Schedule) of two thousand randomly selected adult household residents of Edmonton, Alberta, Canada.

Diagnoses used here are lifetime. Odds ratios (O.R.) are used to estimate relative risk. The results show that having had any psychiatric diagnosis increased the risk for being involved in spouse abuse and child abuse. Particularly high risk was found in those with alcohol abuse or dependence plus antisocial personality or depression, 63.7% of such persons having been involved in spouse abuse and 16.4% in child abuse. Altogether 45% of spouse abusers and 59% of child abusers had lifetime diagnoses of major depressive episode, alcohol abuse/dependence, or antisocial personality. These findings suggest a strong relationship between spouse abuse, child abuse and psychiatric disorders and indicate the need for close co-operation between psychiatrists and social agencies involved with spouse abuse and child abuse.

Introduction

The Research and Information Newsletter is published by the Mental Health Child Welfare Research Unit in order to make it possible for Departmental individuals and groups to keep abreast of current research and information related to Mental Health, Child Welfare, and other Departmental programmes.

The Newsletter will present abstracts or summaries of selected relevant articles or papers produced by Departmental Staff. These will include new projects, published and unpublished papers, conference presentations, as well as research news.

If you feel you have an article which you think should be included in an issue of the Newsletter, please submit a summary of your work (maximum 1000 words).

Adolescent group work

Adolescent group work in a rural northern setting

I.K. MacKenzie
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We had been told on numerous occasions that adolescent groups would not work in a small rural setting. We were told that too many of the group members would know each other and that this would inhibit cohesion and intimacy. It was thought that members would fear that confidentiality would not be kept.

Recently, our clinic tested this hypothesis. For a five-month period a treatment-support group was held for female adolescents between the ages of 13 and 17. The only criterion for referral was that the members were to have been experiencing interpersonal problems within the family. The intent of the group was to promote appropriate developmental tasks of adolescents, such as furthering interpersonal skills with peers and beginning disengagement from family systems. Goals in treatment included exploring:

(1) inter-relationship difficulties
(2) feelings of powerlessness in the family
(3) feelings of rejection in the family
(4) feelings of isolation and uniqueness in the family, with regard to individual problems

continued on page 2

Adolescent groups continued from page 1

(5) feelings of unfulfilled desires for nurturance
(6) feelings of family being too involved in member's life
(7) poor self-image.

Referrals were accepted from Mental Health Services and Child Welfare Services only. Thirty-two appropriate referrals to the group were made. Of these thirty-two referrals, eleven attended regularly and group size fluctuated between six and eleven.

In leading the group, as leaders we utilized what can be called the "stage model" approach to leading groups (Maier, 1981). This approach has similarities to structural and strategic family therapy where focus is placed on interactions in the group and on producing change through these interactions. In this type of group the role of the leaders is on of a facilitator; the leader facilitates interactions which produce change. The group leader is intent on creating connections between the thinking of one member and that of another. As the members see common concerns, they seek to explore them. To facilitate the interactions we, as leaders, used techniques such as reframing, restructuring, role modelling, communication fixing and problem solving — techniques that are also used in systems family therapy.

Topics discussed in group included:
(1) relationships in family, especially with mothers
(2) rejection by family
(3) "How I'm told how I'm a bad kid"
(4) physical abuse
(5) "How I am controlled by my family"
(6) male friends
(7) older boyfriends
(8) come ons
(9) self-perception
(10) traumatic experiences
(11) sexual abuse
(12) rape
(13) interdynamics of group
(14) teenage pregnancy
(15) running away
(16) suicide
(17) alcohol
(18) lying
(19) sexuality — "I'm called a slut"

Two films on adolescent family problems were also shown.

As a whole, the group functioned adequately. Confidentiality was not an issue and the fact that numerous disclosures ranging from alcoholism to incest came out was indicative of the willingness to discuss openly and the amount of trust that was present.

As group leaders, there were many thing we learned and will change for our next group this fall. However, there is proof that group work is possible in a small rural setting. It has also been shown that along with a need for this kind of service, adolescents can adapt well to group work and respect confidentiality.

RECENT ADDITIONS TO THE ALBERTA MENTAL HEALTH SERVICES LIBRARY

1. *Linking Families to Their Institutionalized Elderly*
   S. Achewich
   Rosehaven Care Center
   679-1411

2. *Survey Results of the General Resident Satisfaction Questionnaire and the Beauty Parlor's Resident Satisfaction Questionnaire*
   M. Butt, E. Smith, and E. Patterson
   Claresholm Care Centre
   625-3301

3. *Young Offenders and Child Welfare*
   P. Dion, R. Hoehn, E. Rachmustruck
   Quantitative Methods and Analysis, Policy and Program Development
   427-2635

4. *Human Figure Drawing of Physically Abused Children*
   D. Engram and A. Thomas
   South Region
   181-5260

5. *Estimating the Lifetime Risk of Psychiatric Illness from Survey Data*
   S.C. Newman
   Head Office
   427-2816

6. *Statistical Summary of the Edmonton Region for 1983, 1984, 1985*
   J.M. Provencher
   Edmonton Region
   427-4444

7. *Edmonton Regional File Audit Procedure*
   J.M. Provencher
   Edmonton Region
   427-4444

8. *Evaluation of Provincial Quality Audits: Interim Report*
   J.M. Provencher
   Edmonton Region
   427-4444

9. *A Preliminary Investigation of AMHS Urban Program Single Contact Cases*
   J.A. Sneep
   Edmonton Region
   427-4444

10. *Controversial Treatments: Ethics or Practice*
    A.H. Thompson
    Head Office
    427-2816

11. *Young Offender, Child Welfare and the Mental Health Caseload Communalities*
    A.H. Thompson
    Head Office
    427-2816

Treatments for emotionally disturbed children

Evaluation of residential, home care, day treatment and community clinic treatment for emotionally disturbed children

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Manager

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This descriptive study examined selection differences in background and pre-treatment adjustment variables for children admitted to residence, home-care, day-treatment and community clinic programs at Thistletown Regional Centre, Toronto, Ontario. The general objective was to determine clinical decision rules which could be tested in terms of the success of the children chosen for residential and alternatives to residential treatment. Information on sociodemographic characteristics of children and families was collected at admission, with parents' perceptions of child and family functioning and teachers' perceptions of school behavior collected at admission, discharge, and at follow-up six months after discharge. Indicators of client satisfaction were also obtained from parents at discharge and follow-up. Degree of goal attainment for each client and family was independently assessed at follow-up through individual follow-up interviews.

The results indicated that children admitted to residence differed from those in community-based treatments but most reliably from those admitted to community clinic on both demographic variables and pre-treatment functioning indicators; describing opposite ends of a continuum of severity of disturbance.

Similarly, children admitted to home care, day treatment and community clinic did differ from one another, although not as clearly as residence did from non-residence. There was some evidence for a continuum of severity within community-based treatment, with home care most different from community clinic but similar on most variables to day treatment. Community clinic data appeared to reflect the least disturbed clients and families. Clinic cases did not show a wider range of presenting problems and family functioning, as was hypothesized.

No significant association was found between general satisfaction or perception of current functioning and type of treatment achieved.

Analysis of individual goals indicated the residence and day treatment focussed more on the identified patient than did home care or community clinic, whose goals were aimed more at parents and family as a whole. Home care and community clinic goals reflected emphasis on observable behavior, whereas residence and day treatment concentrated more on feelings. Degree of goal attainment was not associated with treatment received.

The combination of sex, treatment, age at admission, length of treatment, family conflict score, concern with problems, family communication score, and number of previous outpatient treatments did not predict success at follow-up as measured by the goal-oriented scale global score.

At follow-up, in terms of behavior at school, community-based treatment was not more effective than residential treatment, with initial level of severity considered in the analysis. The residential edge over home care observed at discharge was not maintained at follow-up. With regard to family functioning, day treatment was more effective than residence and the other community-based treatments on two of nine factors; the day treatment edge over the other treatments observed at discharge was increased at follow-up.

These results were discussed in the context of recent research and of the need for new conceptual frameworks for government and agency policies to enhance the provision of community-based alternatives.

Demographic Trends in Alberta

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Quantitative Methods and Analysis
Social Services
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According to Alberta Bureau of Statistics population projections, the population of Alberta is expected to grow at an average rate of 1.5 percent between 1986 and the year 2000, a considerably lower growth rate than in the past fifteen years. The change in growth indicates a different future composition of Alberta's population and implies changing needs for social and health services. A study was conducted to analyze the nature and causes of the observed and expected demographic trends. Combined with information on socio-economic trends, general impacts on the size and composition of the target populations of social and health services are identified in the study.

During the 1986 to 2000 period, a shift to a more aged population in Alberta is projected. The changes in age categories are estimated to be: 0-17 (+16.4%), 16-17 (+33%), 18-64 (+25.8%), 55-64 (+31%), and 65+ (+43.6%). The only expected decrease is in the pre-school age group (-4%). The changing demographic structure is mainly attributed to a decline in fertility rates, the aging of the baby boom generation (born between 1950 and 1965), relatively stable mortality rates (at 1981

continued on page 4

Recent Publications by Departmental Staff

1. Bland, R.C., *Epidemiology of Psychiatric Disorders*. Medicine North America, 36, June 1986. Head Office, 427-2816

2. Martens, T., Lyons, B., Sauer, R., *The Yellowhead Family Sexual Assault Program.* Alberta Psychology, Vol. 15, No. 2, March-April 1986. Edmonton Region, 427-4444

Demographic trends continued from page 3

levels) and gradual net migration gains expected after 1987. In sum, the proportion of Alberta's population 18 years of age and over is expected to increase from 69.7% in 1980 to 73.0% in the year 2000 while the proportion of those 0-17 years of age will decrease from 38.3% in 1980 to 27.0%.

The analysis of expected population trends for Alberta by age groups together with a closer examination of emerging trends in family structure, lone parents, women in the work force, persons living alone, the elderly, the handicapped, and the Native population offers a solid basis for anticipating changes in demand for services. Among others, evidence suggests that the trends towards smaller family size and the increased preference for couples to live without children will likely intensify. This is expected to have a dampening effect for the demand for children's services. On the other hand, the number and proportion of families where both parents are working is expected to increase, thus creating a greater demand for child care services. In general, women are expected to participate even more in the labor force, increasing from a rate of 44% in 1971 to 58% in 1981 and to an expected rate of 74% in the year 2000, which is very close to the male participation rate at 80%. This trend indicates a further change in child rearing practices towards out of home care. Rising divorce rates will increase the number of lone parent families. The marriage/divorce ratio has drastically increased from 10:2.3 in 1971 to 10:3.8 in 1981 and is expected to reach 10:4.9 at the turn of the century. This may impact on a number of social and health services dealing with family break-ups. In addition, as female lone parents are expected to prevail in low income groups, they will continue to be a significant portion of the Social Allowance caseload.

AHMS Symposium: Call for presentations

The 1987 Alberta Mental Health Services Symposium will be held on June 15th and 16th once again at Claresholm Care Centre.

An importance feature of the conference will be the participation of AMHS Regional and Institutional staff via paper presentations. All AMHS staff are encouraged to submit proposals for presentation. Presentations might include descriptions of innovative treatment programs, results of research projects, program evaluations, and any other discussions directly or indirectly related to our services. These should be a maximum of 45 minutes in length.

Proposals should be sent to Deanne Cowley, Head Office (427-2816), and should include the following:

1. title of presentation
2. a 200 word (maximum) summary of the presentation
3. the names and titles of the presenters
4. business mailing addresses and phone numbers of presenters
5. expected length of time required
6. requirements for audio-visual equipment.

Policy and procedures

Alberta Mental Health Services research policy

As an important adjunct to our service delivery responsibility, high quality research by Alberta Mental Health Services employees is encouraged by senior management.

For those interested in research, the following points paraphrased from the Alberta Mental Health Services Research Policy may be of interest.

- All proposals for research must pass a research and ethics review before commencement of the study.
- Approval for the commencement of a study that has received research and ethics approval is the responsibility of the Director of the institution or region.
- Management approval for an employee to engage in research will ordinarily imply that such activity is a *bona fide* work activity and carries with it entitlement to normal administrative support (typing, copying, supplies, etc.).
- Alberta Mental Health Services employees may apply for research grants from recognized funding bodies in situations where cost is a factor.
- Employees are encouraged to publish their results in scientific journals and/or present them at professional conferences.

If you wish to receive a copy of the research policy, please contact Gus Thompson at the Head Office (PROFS SD948004).

RESEARCH & INFORMATION
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Alberta
COMMUNITY AND OCCUPATIONAL HEALTH

Volume 1 Number 4 Winter 1986

RESEARCH & INFORMATION

MENTAL HEALTH & CHILD WELFARE NEWSLETTER

Child Welfare

Child Welfare case file review: The provincial view

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D.M. Fuhr
Research Assistant

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427-2816

In late 1984, a province-wide case management review of all active permanent and temporary ward files was undertaken by the child welfare branch of ASSCH, in response to the Thomlison (1984) Report. File reviews were conducted by professionals to assist in individual case planning and to identify those at risk. In general, this information has been used for individual case planning and has not been summarized in a way that would give a province-wide picture of the results.

The present study was initiated in order to obtain this province-wide estimate of the number and characteristics of children in care who are at risk.

Twenty percent of available files were randomly selected, resulting in a sample size of 878. The assessments and observations made by the professional reviewers were computer-coded for overall analysis. These included a number of care factors and client characteristics. A complicating factor involved the use of two different recording forms that collected slightly different data. This factor does not affect the meaning of the information below. [Interested people may obtain a copy of the full report from the authors.]

Of the 780 subjects whose racial origins were known, Natives were over represented at 44.2%. The most common placements of the subjects were foster homes (54%), followed by group homes (13%).

Regarding care factors, the mean number of placements for each child was 5.0 (range=1 to 44). The mean number of social workers who, over time, were assigned to each case was 4.5 (range=1 to 20). The mean number of months in care was approximately 49 (range=1 to 226).

Twenty-four percent had no contact with either their parents/guardians or siblings.

Reviewers rated personal characteristics of the clients thought to be risk factors as follows:

Loss or disruption of a significant relationship	44.5%
Behavior problems	43.5%
Depression	27.2%
Changes in behavior	24.6%
Chronic or critical illness	22.1%
Withdrawal	14.4%
Suicide potential	14.3%
Compulsory care certificates or orders	9.0%
Without significant relationships	8.7%
4 or more placements in last 6 months	6.2%
Suicide attempts	2.7%

The overall prevalence of risk, using the number of risk factors as the criterion, suggest that 627 or 71.4% are thought to be at risk on at least one factor, with 49% at risk on two or more factors. A similar analysis carried out on only those factors that reflect mental health symptomatology (these include suicide attempts or potential, depression, behavior problems or changes, and loss of a significant relationship) resulted in an estimate of 68.5% being at risk on at least one measure, and 43.1% on two or more.

According to the raters, a very high proportion are at risk, whether it be for general care factors or mental health related problems. This, along with other research, indicates that children in care represent the highest risk group that has been identified for mental health problems.

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If you feel you have an article which you think should be included in an issue of the Newsletter, please submit a summary of your work (maximum 1000 words).

Native therapy

Integrative therapy with Native families: Developing an approach

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Numerous briefs have been prepared by Native and non-Native groups and several research reports make cursory reference to mental health needs. However, only a handful of mental health agencies and private practitioners have made a concerted effort to deal with dysfunctional Native Canadian families with culture-specific family therapy. The variety of family therapy approaches in present practice have been developed in Euro-American social-cultural contexts, and are most effective in treating people who live and work within the bounds of those environments.

Canadian aboriginal families present a unique challenge to culture-sensitive family therapists. These families are usually grouped into status, non-status, Metis, and Inuit. Though they are not strictly immigrant groups, they unfortunately are cultural aliens like the immigrants and share the problems of cultural adaptation.

The importance of providing culture-specific family therapy for Native Canadians in Alberta is underscored by the fact that the treaty Indians on reserves, the Metis colonies, and the urban Natives present different cultural realities. Omission of critical cultural factors results in a high drop-out rate of Native families in therapy; in fact, failure to engage in therapy in the beginning stages is very well known by Native and non-Native counsellors. It must be noted that the Canadian experience is not similar to the American experience and that American practices are not necessarily transferable into the Canadian context. With the foregoing assumptions in mind, the researcher conducted a needs assessment and a training program in the Native community over the past two years.

At a needs assessment conducted in 1985, Native counsellors requested the development of culture-specific family therapy approaches. The purpose of the needs assessment was to explore the characteristics and to begin to develop a typology of Alberta Native Indian families with special reference to family therapy. Information was gathered from a number of Native helpers who work with Native families. The needs assessment culminated in a needs forum on counselling Native families. The forum was divided into three principle parts:

1. Attitudes and values within Native families
2. Traditional and Euro-American interventions
3. Needs identification

The results of this exploratory investigation indicate that there is an urgent need to develop culture-specific family therapy approaches for working with Native families. In response to the overwhelming success of the needs forum the author conducted a two-pronged Native counsellors training program in 1986. The aims of this project (an action research approach) were (a) to continue the needs assessment by actively providing training and consultation to Native counsellors, (b) to further gain information about and to develop intervention strategies for urban and reserve families. Because of resource limitations, Metis colonies were omitted. A reserve and an urban Native counselling service were selected. In each location, over a two month period, four modules were presented as follows:

1. (a) Attitudes and values clarification of counsellors toward an integrated approach. (b) Introduction to systematic assessment of families.
2. (a) Cultural identity fragmentation of dysfunctional Native families and overlapping world views of counsellor and family. (b) Helping families through culture-specific approaches and restructuring.
3. (a) Internalized and externalized stress reactions of Native Indians. (b) Integrating traditional and Euro-American methods of helping regenerating.
4. (a) Referrals and resources. (b) Project evaluation.

Each module allowed for ongoing feedback and opportunities to compare and to merge traditional methods of helping with "conventional" psychotherapies. The reserve clearly identified depression in the family, adolescent precriminality, family violence, family sexuality, shyness, and low self esteem as target areas of principle concerns with dysfunctional families. The participants contributed significantly in delineating strengths, limitations, and potentials of the reserve family, and these were catalogued for further investigation. A number of significant culture-specific characteristics were matched with intervention strategies. "Cultural identity fragmentation" was identified as a significant factor in individual psychopathology and family disintegration. Integrated strategies were recommended utilizing Native spirituality as well as some elements of the Euro-American family therapies. In times of psychosocial distress and physical illness some Native families rely heavily on their Christian belief, which, although different than Native spirituality, is not incompatible with cultural tradition to seek spiritual remedies.

Some of the urban findings were consistent with those of the reserve, particularly cultural ambivalence or cultural identity fluctuation. A significant number of Native Indians in trouble with the law appear to have a fragile cultural identity structure. Like the counsellors on the reserve, the urban counsellors listed a number of characteristics of urban Natives which were catalogued for further investigation. The heterogeneity of the urban population poses a greater difficulty in matching to standardize a small number of approaches for a reserve. The transient nature of the variety of Native "cultures" in the urban setting demands a more vigorous research methodology. Important to both groups, and more so to urban Natives, is the addition of psychoeducational and purely educational interventions which will ground the client systems in their cultural identity.

In conclusion, traditional and religious healers can be especially useful in the treatment of on-reserve and off-reserve Native peoples in Alberta. In many cases, providing cultural education may be sufficient to produce clinical recovery. It should be mentioned that Euro-American psychotherapies have elements in common with traditional and religious healing. Both depend on the healers' and the clients' shared ideas about the causation and, by implication, the treatment of the dysfunction. The author, together with counsellors in these two locations, is continuing with the development of an integrative approach to family therapy with Native Indian families.

Suicide prevention

Suicide prevention: A school based program for adolescents

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Kim Adria
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The prevalence of suicidal behavior among adolescents has been of increasing concern to teachers, school administrators, parents, students and mental health professionals. In response to this concern, teachers, politicians and suicidologists have embarked upon several courses of action that may be preventive in nature. For example, teachers are inviting mental health professionals to come and speak to their classes on the topic; politicians in such places as California, New York, and New Jersey are introducing and passing legislation making the teaching of suicide prevention in the high schools mandatory; and suicidologists together with educators are developing suicide awareness curricula for youths in the school systems. All these efforts are based primarily on the assumption that information about suicide together with the development of life skills will both facilitate the early identification and intervention in a suicide crisis and promote life enhancing rather than self harming choices.

Although in the Province of Alberta legislation requiring the teaching of suicide prevention has not been introduced, a private members Bill was introduced in 1986 encouraging the government to develop suicide prevention programs for both junior and senior high schools. This motion was passed unanimously.

In line with the motion, the Department of Education has included a suicide awareness section in their new junior high health curriculum that is currently being introduced in Alberta. The Department of Community and Occupational Health, through the office of the Provincial Suicidologist, has recently completed a Suicide Awareness Program that can be used by teachers. The overall goals of the program are for adolescents to become aware of their attitudes towards suicide, to improve their ability to identify and respond to suicidal behavior in others, and to improve their individual abilities to cope with frustration, depression, and loss.

In order to accomplish these goals, teachers work through the following five major topic areas: awareness, perspectives, indicators, helping, and moving on. The awareness section begins with a discussion of feelings and the acceptability of such emotions, then moves towards helping students understand the complexity of suicide by increasing their level of knowledge about self harming behavior. In perspectives, students are challenged to broaden their understanding of suicide from a personal to a cultural, religious and legal perspective. In the next two sections, indicators and helping, students learn to identify the signs and symptoms of an adolescent who is in emotional difficulty, and acquire some skills in assisting the troubled adolescent to find an appropriate helping resource. Moving on, the last section of the program, assists students not only in examining the impact of the suicide or suicide attempt on family and friends but also in providing knowledge about the grieving process. An "up beat", life enhancing exercise completes the three week program.

How a program such as this is to be implemented in view of the possibility that it may in fact increase rather than decrease suicidal behavior (iatrogenesis) requires training, community support, and commitment. Indeed, the implementation of the program is designed in such a way as to involve Mental Health Services in the provision of support to school personnel and crisis intervention to "at risk" students that cannot be adequately helped within the context of the school. Furthermore, school counsellors and psychologists involved in the participating schools will be expected to enrol in the two-day Provincial Suicide Prevention Training Program in order that they can become more knowledgeable about suicide. The Provincial Suicidologist will provide two days of in-service training to educators involved in using the Suicide Awareness Program. It should be noted that before this program becomes available throughout the province, it is important to field test the materials in several schools for the purpose of evaluating and fine-tuning the program.

To assist students to become tolerant, self confident, and capable individuals who are able to act in ways that will improve their own lives and the life of their community is extremely important. It is hoped that the Suicide Awareness Program will make such a contribution.

Recent projects approved by Alberta Mental Health Services research and ethics review

1. Family Study of Mental disorders
   R.C. Bland
   Head Office
   427-2816

2. Suicide Behavior in Adolescents
   R. Dyck
   Head Office
   427-2816

3. Interpersonal Problems Among Chronic Psychiatric Patients
   G. Ekisa
   Edmonton Region
   427-4444

4. Family Day Home Review
   P.S. Peters
   Community Day Programs
   427-9915

5. Self-Esteem and Child Sexual Abuse
   G. Read
   South Region
   181-5260

6. A Proposal to Identify and Assess the Needs of Persons Affected by a Disaster
   K. Roberts and F. Langer
   Head Office
   427-2816

Recent publications by departmental staff

1. Bland, R.C., Newman, S.C., Orn, H., *Recurrent and noncurrent Depression.* Archives of General Psychiatry, Vol. 43, November 1986, pp. 1085–89.
   Head Office 427-2816

2. Lyons, B., *Yellowhead Family Sexual Assault Program: Rural Model for Treating Sexually Abused Children and Their Families.* Rural Community Mental Health Newsletter, Vol. 13, No. 1, p. 12, 1986.
   Edmonton Region 427-4444

3. Pettifor, J.L., *Patient Rights, Professional Ethics, and Situational Dilemmas in Mental Health Services.* Canada's Mental Health, September 1985, pp. 20–23.
   Calgary Region 297-4520

4. Pham, T.N., *The Mental Health Problems of the Vietnamese in Calgary: Major Aspects and Implications for Service.* Canada's Mental Health, December 1986, pp. 5–9.
   Calgary Region 297-7311

5. Smith, S.A., Achkewich, S., Wilton, T., *A Rural Mental Health Delivery System in Alberta.* Canada's Mental Health, December 1986, pp. 16–17.
   Rosehaven Care Centre 679-1411

6. MacDonald, L., *Ethical Standards for Therapeutic Programs in Human Services: An Evaluation Manual.* The Behavior Therapist, 1986, g, pp. 213–215.
   Community Behavioral Services 427-2065

Recent additions to the Alberta Mental Health Services Library

1. *Report on Research*
   Mental Health Services
   April 1, 1985 – March 31, 1986
   D. Fuhr
   Head Office, 427-2816

2. *Funded Agency Retrospective*
   Mental Health Services 1985–86
   L. Gardner and K. Radchuck
   Head Office, 427-2816

3. *Critical Incident Stress Debriefing and the Mental Health Services Mandate — A Discussion Paper*
   B.E. Krewski
   Edmonton Clinic, 427-4444

4. *Consumer and Therapist Evaluation of Service Delivery and Therapy Sessions in Mental Health Rural Area Clinics*
   H. Neidermayer and C. Gayton
   Northwest Region, 538-5160

5. *Edmonton Region Quality Audit Committee: Report on Activities*
   M. Provencher
   Edmonton Region, 427-4444

6. *Edmonton Region A.M.H.M.P.S. Reliability Study*
   M. Provencher
   Edmonton Region, 427-4444

7. *Analysis of Cases Diagnosed with Family and Psychosocial Problems*
   M. Provencher
   Edmonton Region, 427-4444

8. *Mental Health Survey of Home Care Programs*
   K. Radchuck and L. Gardner
   Head Office, 427-2816

9. *Approved Home Focus Groups Report*
   C.A. Roberts
   Head Office, 427-2816

CONFERENCE ANNOUNCEMENTS

September 16–18, 1987. American Association on Mental Deficiency Region IV Annual Conference: "Working Towards Self-Sufficiency." Edmonton, Alberta

For registration information or paper submissions, contact:

Dr. Steven Dennis
13325 St. Albert Trail
Edmonton, Alberta, T5L 4R3
Phone: (403) 454-9656

RESEARCH GRANTS

- Congratulations are due to Dr. Steve Newman who recently received a $31,500 grant from the Provincial Mental Health Advisory Council. The grant will be used to study mortality in approximately 3,000 patients with schizophrenia. Dr. Newman is an epidemiologist for Alberta Mental Health Services.

- Alberta's Wild Rose Foundation awarded a $30,000 grant to the newly-founded Canadian Association for Research in Rehabilitation (CARR). The grant was awarded for publication of the Alberta-based CANADIAN JOURNAL OF REHABILITATION. The journal is aimed at professionals and students within the broad field of rehabilitation of persons with disabilities. The quarterly journal will publish in both official languages, with the premier issue scheduled for national distribution in September 1987.

RESEARCH & INFORMATION
MENTAL HEALTH & CHILD WELFARE NEWSLETTER
is published quarterly by Mental Health/Child Welfare Research Unit and distributed to departmental employees interested in research issues and related information.

Editor: Deanna Fuhr, 427-2816

Alberta
COMMUNITY AND OCCUPATIONAL HEALTH

Volume 2 Number 1 Spring 1987

RESEARCH & INFORMATION
MENTAL HEALTH & CHILD WELFARE NEWSLETTER

Ethical Standards

Ethical standards for therapeutic programs in human services: An evaluation manual

L. MacDonald
Director
Community Behavioral Services
(Edmonton Region)
427-2065

Published in:
The Behavior Therapist, 1986, Volume 9, Number 10, pp. 213-215.

Introduction

The Research and Information Newsletter is published by the Mental Health Child Welfare Research Unit in order to make it possible for Departmental individuals and groups to keep abreast of current research and information related to Mental Health, Child Welfare, and other Departmental programmes.

The Newsletter will present abstracts or summaries of selected relevant articles or papers produced by Alberta Community and Occupational Health and Alberta Social Services Departmental Staff. These will include new projects, published and unpublished papers, conference presentations, as well as research news.

If you feel you have an article which you think should be included in an issue of the Newsletter, please submit a summary of your work (maximum 1000 words).

Therapeutic programs in the human services field are intended to bring about improved functioning in clients' behavior. While achieving this objective, it is important that clients involved in such programs have the protection of clearly defined ethical standards. Such standards serve as stimuli or as goals for improving therapeutic programs by identifying practices which are considered to be most desirable in terms of our current knowledge of human behavior and current social values.

This manual provides the minimum ethical standards which should exist in therapeutic programs within human services such as those provided under the generic terms rehabilitation, mental health, and child welfare.

The purpose of this manual is to:

1. establish minimum standards;
2. serve as an evaluation tool for assessing the degree to which therapeutic programs meet the minimum standards; and
3. document an increase or decrease in compliance with standards over time.

Contents

Section II of the manual contains minimum ethical standards for therapeutic programs, organized under seven basic operational areas:

1. goals of treatment;
2. choice of treatment;
3. voluntary participation;
4. interests of client
5. adequacy of treatment;
6. confidentiality;
7. competency of therapist.

An ethical principle is stated for each operational area. Under the principle is a list of standards identifying the specific conditions, functions, or activities which are required to fulfill the standard. The standards are operational to the extent that they either exist or do not exist for a particular therapeutic program. A "yes" or "no" response can be registered for each standard.

Section III of the manual is a summary and recommendation sheet. This sheet is used for providing feedback on program evaluations.

In this manual, the term client is used to describe the person whose behavior is to be changed; therapist is used to describe the person in charge of the intervention; and treatment refers to the general method of behavioral change.

Therapist Responsibilities

It is the responsibility of each therapist to ensure that his/her programs meet or exceed the minimum ethical standards identified in this manual. For each standard, there should be objective evidence that efforts are being made to abide by the standard.

Annual Reviews

Because of the increasing need and demand to provide ethically appropriate treatment, it is recommended that evidence of compliance with each of the standards be identified through an annual review of a select number of clients programs within a human services agency.

continued on page 2

Continued from page 1

This annual review process should be carried out by an Ethical Review Committee composed of three external representatives who are familiar with general human service programs and have some knowledge of ethical issues and program design.

Procedures

The review is expected to be completed in one day, involving interviews, observations, and on-site inspection of activities in the seven basic operational areas.

Committee Report

A report, prepared by the Committee, should indicate the overall rating of the program, the ratings obtained on each standard, and the comments and recommendations of the Committee (i.e., parts II and III of this manual). This report should be briefly discussed with the supervisor responsible for the program and within one week sent to the supervisor and to the director of the agency.

Supervisor's Reply

It is expected that this responsible supervisor will reply, in writing, to the director within 30 days, indicating an objective operational plan, with time lines, to rectify the deficiencies identified in the report.

Internal Review

It is also recommended that the director, supervisor, and therapist responsible for a therapeutic program conduct an independent internal review, at least annually, to identify ethical issues of importance to their services. These internal audits could service as a basis for implementing ethical safeguards as outlined in this manual.

Patient rights, professional ethics, and situational dilemmas in mental health services

J. L. Pettifor
Supervisor
Consultation Services Unit
(Calgary Region)
297-7555

Published in:
Canada's Mental Health, Volume 33, Number 3, pp. 20-23

The moral and ethical values of society are the underlying bases for legislated individual rights, for professional codes of ethics, for agency guidelines for service providers, and for organizations which advocate rights for special populations. While all of these sources of "rights" definitions have a large common element, there are also differences in content and differences in the power of enforcement.

"Rights" as enshrined in legislation, suggest enforcement mechanisms with potentially adversarial situations and litigation. Mental health legislation appears to deal primarily with legal procedures and appeal mechanisms to protect the rights of involuntary psychiatric patients. Regulations and procedures governing community mental health services for voluntary patients are likely to reflect concern for the respect and well-being of patients beyond what is actually enacted in legislation.

Professional staff are expected to respect the formally defined rights of patients, and also to provide quality services within their respective mandates and regulations. However, administrators are cautious about an excessive use of the term "rights" because of the adversarial implications. They may prefer to talk of "responsibilities" — responsibilities of patients to cooperate with service providers and responsibilities of service providers to treat patients with respect and uphold their human dignity. In practice, there are reciprocal relationships between clients and service providers, and adversarial action is not the most productive way to resolve problems. Similarly, while staff are expected to serve clients, they are also expected to avoid adversarial advocacy roles on behalf of clients.

Professional codes of ethics outline the responsibilities of professionals in providing high quality services that place the health and well-being of patients/clients as the number one priority. Violation of these principles is considered professionally unethical, and each profession has mechanisms for investigating documented complaints and imposing sanctions on adjudicated offenders.

However, neither legislated rights nor adopted codes of ethics can guarantee fair, humane patient treatment; violations must be blatant and well documented, and must usually undergo due process, to bring about redress. Other factors may be equally important in enhancing appropriate and respectful care.

1. Public and professional education and understanding of both legal rights and ethical principles - which, it is hoped, results in vigilant commitment to both law and values;
2. Recognition that, in real life situations, several people may have conflicting rights, that professionals may have legitimate conflicting loyalties, and that in choosing a course of action, all parties may not be satisfied;
3. Recognition that, in addition to compliance with the law, there must be an ethical decision-making process to assist professionals in making the best decisions, and a rationale to assist patients in understanding why certain decisions rather than others are made.

This article deals primarily with voluntary clients in community-based services, which are generally not covered by mental health legislation concerning patients' rights. In specific situations of concern for client rights, judgement is required on whether there is a breach of legal rights, professional ethics, agency policy, or commonly accepted values. In these real life situations, it is often difficult to establish violations of legislated rights, and yet there may be a denial of appropriate and respectful client services. It is not always easy to find ready solutions to dilemmas, even though injustices may be suffered. Skills in decision-making can be increased by practice in resolving situational dilemmas and in identifying the principles involved. Situational dilemmas with illustrative vignettes are discussed under four major headings (1) the rights to respect, dignity and non-discrimination, (2) the rights to appropriate treatment, to consent and to refuse, (3) the right to the least restrictive, least intrusive intervention, and (4) the right to confidentiality of personal inform-

ation, the right to allow or refuse release, and the right to peruse personal records.

It is suggested that the vignettes be reviewed with the following questions in mind:

1. What is each individual/group owed, and why? What are the rights and responsibilities involved?
2. What is the best choice of what should have been done, or should happen next? Why?
3. What minimal change in circumstances would lead to a different choice of action? Why?

Resolutions to dilemmas are not dependent solely on one-to-one relationships, but also on organizational contexts and on how we plan for effective use of human resources in serving the needs of citizens individually and collectively.

Whether we be patients, citizens, volunteers, professionals, administrators or educators, we want humane, accessible, quality services which benefit individuals, communities and society. We need increased public and professional awareness of the issues affecting individual lives, and the skill to balance the rights and responsibilities of many parties against a set of human values.

Sexual abuse

Treatment of sexual abuse victims and their families

B. Lyons
Social Worker
Mental Health Services
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427-4444

For the past three years, Yellowhead Family Sexual Assault Program has provided therapy for victims and their families of intrafamilial sexual abuse. The treatment program is provided by Alberta Social Services (Tony Martens, Huber Smith) and Alberta Mental Health Services (Bob Lyons) working closely with Provincial Court, R.C.M.P., schools and the Solicitor General. Delayed sentencing of the offender for his duration of therapy establishes a court-mandated treatment program. Participation of the family members is voluntary. Our experience is that the family's motivation and subsequent involvement in therapy is high and complete. Screening of the offender by FACS and YFSAP selects offenders who are appropriate for the community-based program.

The treatment program combines Group Therapy (offender, woman, victim and couples) with Reconstructive Family Therapy (individual, didactic and family therapy). The length of therapy is one to one and a half years followed by a suspended sentence of two to three years. To date, internal evaluation has been positive about outcomes of the participants. Presently, Dr. Joseph Hornick is evaluating the YFSAP through funding by Alberta Social Services. His evaluation included pre and post assessment of all individuals and observation of the group processes.

The response by the community has been generally favorable. Initially, as community awareness increased and subsequent disclosures occurred, there was alarm and reaction in some sectors, particularly when Hinton was inadvertently referred to as the "Incest Capital" of Alberta. Present disclosure rates are less than the initial numbers implying that a stockpile of cases were initially disclosed and that present disclosures reflect the current incident of sexual abuse in our population. The catchment area has expanded to Grande Cache, Jasper, Edson and each community initially experiencing similar dramatic increase in disclosures as community awareness heightens followed by more stable current disclosure rate.

The program is now reaching many adults abused as children and victims abused by non-parental figures. Non-abused siblings of victims are also being more specifically addressed. Issues addressed are guilt, anger control, and helplessness which in the past have been less identified with siblings of victims, yet interfere in healthy lifestyle.

Provincial Court Judge, Michael Porter, Tony Martens and the writer recently presented at the *Family Violence —An Integrated Response* Conference in Edmonton. This model of the program is excellently suited for rural communities.

Depression

Recurrent and non-recurrent depression

R. C. Bland
Assistant Deputy Minister

S. C. Newman
Epidemiologist

H. Orn
Research Officer

Mental Health Services
(Head Office)
427-2816

Published in:
Archives for Psychiatry 1986; 43: pp. 1085-1089.

In a study of 763 first degree relatives of 75 probands with unipolar depression (who had been followed up 12 - 18 years after their wide admission), two proband factors were found to produce significant differences in morbidity risks for unipolar depression in first degree relatives. These were (1) proband age of onset — younger age being associated with higher risk, (2) recurrences in the proband — those with recurrent depression producing higher morbidity risk in relatives. These two factors are present in all probands, and although they are independent, they interact. Thus, the lowest morbidity risk is found for probands with late age of onset and no recurrences (3.4%), and the highest risk for these with early onset and recurrences (17.4%), those with late onset and recurrences, and those with early onset but without recurrence, being intermediate at 7.5 - 8.2%. The findings offer a possible explanation of the variability in results found in otherwise well-conducted studies where these factors were not considered, and also suggest a basis for sub-classifying unipolar depression.

The Canadian Journal of Program Evaluation

The journal seeks to promote the theory and practice of program evaluation in Canada by publishing:

Articles on all aspects of the theory and practice of evaluation, including methodology, evaluation standards, implementation of evaluations, reporting and use of studies, and the audit or meta-evaluation of evaluation.

Research and Practice Notes that provide practical examples of the application of particular methodologies or procedures within the context of a particular study or group of studies.

Book Reviews of relevance to the practice of evaluation in Canada.

For further information contact: Joe Hudson, Editor, Canadian Journal of Program Evaluation, c/o Faculty of Social Welfare, The University of Calgary, Suite 300, Campus Tower Bldg., 8625 - 112 Street, Edmonton, Alberta, T6G 1K8.

Recent publications by departmental staff

1. Vanderwell, A., Sawatsky, D. D., Neidermayer, H., *Department of Educational Psychology Doctoral Internship Program.* Alberta Psychology, Vol. 12, No. 2, April 1983, pp. 17-18
   Northwest Region, 624-6151
2. Newman, S., *The Analysis of Hospital Morbidity Data Using Life Table Methods.* In Press: Canadian Journal of Public Health.
   Head Office, 427-2816
3. MacDonald, L., *Ethical Standard For Therapeutic Programs in Human Services: An Evaluation Manual.* The Behavior Therapist, 1986. g. 10213-215.
   Edmonton Region, 427-2065
4. Vokey-Mutch, J., Finstad, M., MacDonald, L., *Does Home-Based Parent Training Reduce Residential Admissions of Children?* Journal of Practical Approaches to Developmental Handicaps, 1986, 10, 23-25.
   Edmonton Region, 427-2065
5. Wilkes, T. C. R., *Management of Affective Disorders in Children.* Update, March 1987, pp. 617-626.
   South Region, 181-5260

Recent projects approved by AMHS research and ethics review

1. Can Changes in Intra-muscular Injection Technique Reduce Site Complication?
   P. Angus
   Calgary Region, 297-7509
2. Outcome of Child Custody and Access Mediation.
   M. Phelan
   Edmonton Region, 427-0731
3. The Mortality of Affective Disorder Patients in Alberta 1976-85.
   S. Newman
   Head Office, 427-2816
4. A Proposal of Work and Leisure Activities For the Chronically Mentally Ill.
   U. V. Prasad
   L. Gardner
   Head Office, 427-2816

Recent additions to the Alberta Mental Health Services library

1. *Qualifications for Certification of Psychologists in Canada and the United States*
   G. Stebelsky
   A. H. Thompson
   Head Office, 427-2816
2. *Coordinated Care of the Psychosocially Disabled.* A Brief Presented to P.M.H.A.C.
   Edmonton Region
3. *Edmonton Region AMHNPS Reliability Study: First and Second Follow-ups*
   M. Provencher
   Edmonton Clinic, 427-4444
4. *The Alberta Mental Health Management and Planning System*
   F. H. Langer
   H. Z. Borowski
   K. L. Walsh
   Head Office, 427-2816
5. *Alcoholism in Alberta, Canada*
   R. C. Bland
   S. Newman
   H. Orn
   Head Office, 427-2816

RESEARCH & INFORMATION
MENTAL HEALTH & CHILD WELFARE NEWSLETTER

is published quarterly by Mental Health/Child Welfare Research Unit and distributed to departmental employees interested in research issues and related information.
Editor: Deanna Fuhr

If you require additional copies of the newsletter, or know of any individual or group that would like to receive future issues, please telephone Deanna Fuhr at 427-2816, Edmonton or write to Mental Health/Child Welfare Research Unit, 4th Floor, Seventh Street Plaza, 10030 - 107 Street, Edmonton, Alberta, T5J 3E4.

Alberta
COMMUNITY AND OCCUPATIONAL HEALTH
Alberta
SOCIAL SERVICES

Volume 2 Number 2

Fall 1987

RESEARCH & INFORMATION

MENTAL HEALTH NEWSLETTER

Geriatrics

Family Support Groups

S. Achkewich
Social Worker
Rosehaven Psychogeriatric Hospital
143-1610

Presented at:
The 16th Annual Scientific and Educational Meeting sponsored by the Canadian Association on Gerontology held in Calgary on October 22-25, 1987.

Family Support Groups link the families to their institutionalized elderly forming a "care-sharing team." Progressive global dementia (Alzheimer's type) can destroy not only the victim but their primary caregiver too.

Families need support and education when confronted with the placement of their elderly relative into a long-term care facility.

Rosehaven Care Centre has established a family support group program. Four, two hour sessions, help families deal with the feelings they may be experiencing and teach them about normal aging, the phases of Alzheimer's Disease, the structure of the institution and practical skills for visiting, advocacy and problem solving.

Family involvement can and does improve the quality of life for the institutionalized elderly.

Introduction

The Research and Information Newsletter is published by the Mental Health Research Unit in order to make it possible for Departmental individuals and groups to keep abreast of current research and information related to Mental Health and other Departmental programmes.

The Newsletter will present abstracts or summaries of selected relevant articles or papers produced by Departmental Staff. These will include new projects, published and unpublished papers, conference presentations, as well as research news.

If you feel you have an article which you think should be included in an issue of the Newsletter, please submit a summary of your work (maximum 1000 words).

Meeting the challenge: Alternative to long term care

S.A. Smith
Medical Director

L. Rowswell
Coordinator, External Services
Rosehaven Psychogeriatric Hospital
143-1610

Presented at:
The 16th Annual Scientific and Educational Meeting sponsored by the Canadian Association on Gerontology held in Calgary on October 22-25, 1987.

Faced with continuing economic pressures and changing political attitudes, Rosehaven researched and selected a programming alternative to long term care for the chronically mentally ill and Alzheimer-type dementia victims: Adult Day Program.

Adult Day Program offers a unique combination of advantages for the dependent adult: 1. a means whereby they may spend time out of their home in a safe, supervised setting, 2. have an opportunity for group interaction and 3. received coordinated patient services directed towards stabilization and maintenance of optimal self-care levels.

Rosehaven's Day Program operates on a medical model; emphasizing remedial programming, socialization and respite for the caregivers. No limit is placed on the duration of the service.

Our program now has a caseload of 30 patients and a waiting list. Although the program's priority is to serve patients being discharged into the community at different levels of housing, community referrals are increasing daily and Rosehaven is responding.

Alberta Mental Health Management and Planning System

AMHMPS: A source of research data

Henry Z. Borowski
Manager, Mental Health
Information Systems
Head Office
427-2816

The Alberta Mental Health Management and Planning System (AMHMPS) maintains information on community services to Alberta Mental Health Services (AMHS) clients. Its primary purpose is to support management planning, and selected aspects of clinical work; nevertheless, AMHMPS data are potentially valuable to researchers.

A. Coverage

The system contains information on clients treated at any of the 54 AMHS outpatient clinics. Since April 15, 1985 all persons receiving a face-to-face clinical service are registered and have a client file on AMHMPS. Previously clients had a choice: they could request that a computer file was not created. The policy was changed because the system's usefulness was adversely affected by the high inter-clinic variability in the proportion of "opted out" clients.

AMHMPS contains information on approximately 105,000 clients who collectively have had 139,000 treatment episodes (activities) between 1976 and 1987. Almost 80 percent of the clients have only been treated once, while another 15 percent have been treated twice. Five percent of clients have had more than two treatment episodes. The system also stores 1.1 million records on therapy sessions (contacts) that have occurred during the same period. Approximately 13,500 activities and 100,000-150,000 contacts are entered on the system annually.

The system includes an organization component, with about 1,400 records primarily on clinic staff. The following section describes the contents of client and organizational components.

B. The client component

Table 1 shows the contents of the major sub-components within AMHMPS. The client area stores unique records that identify the client on the system. To these records are linked one or more activity records, which provide selected details on the treatment episode. The contact area stores service provision details for the appropriate activity. The activity area contains the usual admission/discharge information, while the contact area indicates when a client was served, for how long, by whom, etc.

The client component contains relatively few variables — 45. (Some variables, like primary therapist, area, and location are stored in the organizational area, but can be reported as if they are client data. Consequently, they appear in the activity section of Table 1.) The completion rate for variables is high because 28 variables are mandatory entries and the few remaining ones are important and thus, they are more likely to be recorded.

The data reliability is also enhanced by the system's design and quality assurance activities of staff. First, AMHMPS uses extensive on-line editing to ensure accuracy of information being entered. Secondly AMHMPS unit and regional staff routinely review exception reports and correct any anomalies. Although highly reliable, the system falls short in some areas. Information that was converted from the MHIS to AMHMPS is occasionally problematic. The new system, installed in December 1985, has a fundamentally different design and requires the collection of some additional organizational data. Sometimes histories of therapists' responsibilities for cases of MHIS origin are incomplete.

C. The organizational component

The organization component maintains records on all staff currently working in the community clinics, including clinical and administrative staff and contracted consultants. The contents of the various records storing personnel data are listed in Table 1. Much of this data is mandatory and must be entered when these records are created. Many of the personnel variables reflect the most current situation, i.e., historical data are not retained when changes occur: work location, position function, employment type, reporting location, percent direct time, discipline, class title, full-time factors are such variables.

D. Optional fields

When AMHMPS was redeveloped, only those MHIS client variables that were frequently used were retained. Nevertheless, AMHMPS includes eight optional fields that can capture additional information when special needs arise. Each of the six regions can separately identify the contents of an optional field, which is collected on either a continuous or time limited basis. Optional fields that are used for a limited time can later be used to capture different information. These fields were included to provide flexibility in addressing regional needs, to support research, and to meet special planning needs.

Four of the additional variables can be captured using the registration record and the other four can be captured using contact forms. Presently these fields are not widely used, but the following information is being captured either provincially or in specific regions:

1. native status (provincially)
2. global functioning scores at registration and termination (Edmonton)
3. family violence data (Edmonton)
4. children's mental health service time (Northeast)

The use of optional fields is jointly administered by the regional AMHMPS coordinator and the manager of AMHMPS.

E. Availability of data for research projects

The preceding sections have described the data potentially available to researchers. Because of the confidential nature of the AMHS client data, major external or internal research projects using

data require Research and Ethics Committee review at either the regional or provincial level. However, routine requests for administrative, planning and caseload monitoring information are handled in a more expeditious fashion. The latter are in keeping with the system's primary role of providing management and clinical information.

The system can be of assistance to researchers within AMHS (and, circumstances permitting, to external researchers) in the following ways:

1) by provision of reports — listings and summaries
2) by creation of subfiles containing activity records and summary contact data that can be analyzed by the researchers using statistically oriented programming languages
3) by provision of client listing for random sample selection
4) by collection of research data using the optional fields
5) by providing limited access to computing resources to AMHS researchers.

Although AMHMPS unit is a small one with limited resources and many responsibilities, its staff are willing to assist bona fide research efforts.

The preceding summarizes a longer paper, which is available upon request.

TABLE 1
AMHMPS variables by system area

A. Client Area
Client Number
Names — birth, present
Address
Postal Code
Telephone Numbers
Date of Birth
Gender
Caution — Indicator Type
— Effective Dates

B. Activity Area
Activity Number
Local File Number
Region
Clinical Unit/Area
Primary Therapist
Secondary Therapist
Client's AHCIP Number
Postal Code at Registration
Date of Referral
Referral Source
Registration Date
Marital Status
Historic Child Welfare Status
Public Guardian
Court Involvement
Termination Date
Reason for Termination
Agency Referred to
Therapist's Assignment
Effective Date for a Case
Therapist's Assignment
End Date for a Case

C. Contact Area
Contact Date
Duration
Therapist(s)
contact Location
Service
Number of Clients Present
Number of Therapists Present

D. Organization Area
Employee's Name
Therapist/Personnel Number
Position Number
Employment Type
Discipline
Class Title
FTE Factor
Position Assignment Effective Date
Position Assignment End Date
Supervisor

Epidemiology of psychiatric disorders in Edmonton

Editors:
Roger C. Bland
Stephen C. Newman
Helene Orn

The following articles are being published as a supplement for Acta Psychiatrica Scandinavica in early 1988:

Investigations of the Prevalence of Psychiatric Disorders
R.C. Bland
Design and Field Methods of the Edmonton Survey of Psychiatric Disorders
H. Orn, S.C. Newman, R.C. Bland
Lifetime Prevalence of Psychiatric Disorders in Edmonton
R.C. Bland, H. Orn, S.C. Newman
Period Prevalence of Psychiatric Disorders in Edmonton
R.C. Bland, S.C. Newman, H. Orn
Age of Onset of Psychiatric Disorders
R.C. Bland, S.C. Newman, H. Orn
Morbidity Risk of Psychiatric Disorders
S.C. Newman, R.C. Bland, H. Orn
Prevalence of Psychiatric Disorders in the Elderly in Edmonton
R.C. Bland, S.C. Newman, H. Orn
Attempted Suicide and Psychiatric Disorders in Edmonton
R. Dyck, R.C. Bland, S.C. Newman, H. Orn
Psychiatric Disorders and Unemployment in Edmonton
R.C. Bland, G. Stebelsky, H. Orn, S.C. Newman

RESEARCH GRANTS

• Paula Angus, Mental Health Therapist at the Central Clinic, has received funding from the Alberta Foundation for Nursing Research to conduct research around the issue of "Can change in intramuscular injection technique reduce injection site complications?"

Recent additions to the Alberta Mental Health Services Library

1. *Community Residential Services Planning Survey*
   Mental Health Residential Services
   Client Profiles
   A. MacDonald
   Calgary Region, 297-7509
2. *Current ABS. Norms for a Large Institutionalized Population of Persons with Mental Retardation: A Comparison with the 1974 Norms*
   D.J. Piercey and J.W. Ho
   Central Region, 340-5560
   Presented at: 111th American Association on Mental Deficiency, L.A., C.A., May 1987.
3. *Obtaining Disclosure of Domestic Violence*
   G. Carter
   Edmonton Region, 427-4444
4. *General Resident Satisfaction Questionnaire and the Beauty Parlor's Resident Satisfaction Questionnaire*
   E. Patterson
   Claresholm Care Centre, 625-3301
5. *Report on the Status of Research 1986 Edmonton Region*
   Alberta Mental Health Services
   J. Eustace
   Edmonton Region, 427-4444
6. *Self-Employment and Creative Activities for Chronically Mentally Ill*
   P. Shimp and D.K. Yurkiw
   Extended Care Services, Calgary Region, 297-4545
7. *Alberta Social Services/Alberta Mental Health Task Group on Children's Mental Health Services, June 1986*
   Calgary Region: Preliminary Report on Children's Mental Health Services
   J. Martin
   Calgary Region, 297-4575
8. *Report on Research — Mental Health Services*
   (April 1, 1986 - March 31, 1987)
   AMHS (Head Office) Research Unit
   Head Office, 427-2816
9. *Suicide Trends in Canada, 1956-1981*
   R.J. Dyck
   S.C. Newman
   A.H. Thompson
   Head Office, 427-2816
10. *Suicide Prevention for the Young: Program Possibilities*
    R.J. Dyck
    Head Office, 427-2816
11. *Suicide Attempts and Psychiatric Disorders in Edmonton*
    R.J. Dyck
    R.C. Bland
    S.C. Newman
    H. Orn
    Head Office, 427-2816 and the Department of Psychiatry, University of Alberta, 432-6576
12. *On the Age-Period-Cohort Analysis of Suicide Rates*
    (Analysis of Suicide Rates)
    S.C. Newman
    R.J. Dyck
    Head Office, 427-2816
13. *Crisis Initiated Intervention: A Proposed Pilot Project for Slave Lake*
    Mental Health Services
    P. Haines
    Northwest Region, 849-7297
14. *An Identification and Assessment of the Needs of Persons Affected by a Disaster*
    C.A. Roberts
    Edmonton Region, 427-4444

RESEARCH & INFORMATION
MENTAL HEALTH & NEWSLETTER

is published quarterly by the Mental Health Research Unit and distributed to Departmental employees interested in research issues and related information.
Editor: Deanna Fuhr

If you require additional copies of the newsletter, or know of any individual or group that would like to receive future issues, please telephone Deanna Fuhr at 427-2816, Edmonton or write to Mental Health Research Unit, 4th Floor, Seventh Street Plaza, 10030 - 107 Street, Edmonton, Alberta, T5J 3E4.

Recent projects approved by Alberta Mental Health Services Research and Ethics Review

1. Northwest Alberta Family Violence Research Project
   K. McKenzie
   N. MacKenzie
   G. Leger
   Alberta Social Services, 422-5916

Volume 3 Number 1 Winter 1988

RESEARCH & INFORMATION

MENTAL HEALTH NEWSLETTER

Criminology and Mental Health Needs

Young Offenders, Child Welfare and Mental Health Caseload Communalities

A. H. Thompson,. Ph.D., Director of Research and Evaluation/Senior Psychologist
A.M.H.S. (Head Office)
Ph.: 427-2809 (147-2809)

(In press: Canadian Journal of Criminology)

The proclamation of the Young Offenders Act in April of 1984 brought with it the potential for increased attention to the mental health needs of those charged under its authority. From another angle, a number of authors have suggested that studies on the interrelationships of corrections, mental health, and child welfare systems are needed in order to gain a comprehensive understanding of the way in which society deals with troubled youth. The present study was thus designed to examine the caseload overlap of Alberta Mental Health Services and Child Welfare on a sample of Youth Offenders.

Records of the first 2539 individuals charged under the Young Offenders Act in Alberta were matched with records of the Provincial community mental health service and the Provincial Child Welfare system in order to determine the extent of case overlap. Selected file data were also retrieved in order to provide a descriptive profile of the sample. Forty-seven percent of Young Offenders had been previously assigned Child Welfare status, while 18% had been on the caseload of Alberta Mental Health Services. Although the overlap is significant, important differences were found that need to be considered in service planning. That is (1) individuals who had also been on the Mental Health and/or Child Welfare caseloads were more likely to have been involved in crimes against persons, (2) although Natives were significantly over-represented in the Young Offender sample (in comparison to the general population), the proportion was about one-half of that found in the general Child Welfare caseload, and (3) not surprisingly, Young Offenders were more likely to have received a diagnosis of "conduct disorder" than those on the general Mental Health Services caseload.

The extent of case overlap, which is a conservative estimate, supports the view that whereas we may have a large number of separate services corresponding to distinct social or human problems, we may be dealing with a much smaller number of high-risk groups who will exhibit behavior that brings them to the attention of a variety of agencies. This is in line with the position that a variety of mental and social problems stem from a similar root cause. Implications for service delivery are (1) support for the often called for improvements in integration/coordination of services, and (2) preventative intervention at the Child Welfare level may forestall later "graduation" to the Young Offender system.

Introduction

The Research and Information Newsletter is published by the Mental Health Research Unit in order to make it possible for Departmental individuals and groups to keep abreast of current research and information related to Mental Health and other Departmental programmes.

The Newsletter will present abstracts or summaries of selected relevant articles or papers produced by Departmental Staff. These will include new projects, published and unpublished papers, conference presentations, as well as research news.

If you feel you have an article which you think should be included in an issue of the Newsletter, please submit a summary of your work (maximum 1000 words).

Mental Retardation

Adaptive Behavior Scale Norms

Dr. David Piercey
Psychologist
Psychological Speech and Language Services, Michener Center
Red Deer, Alberta
T4N 5Y5
Ph: 340-5600 (151-5662)

Presented at The 111th Annual Convention of the American Association on Mental Deficiency, held in Los Angeles, CA; May, 1987.

A large institutionalized population (N=1281) consisting of persons with mental retardation, and variously at all AAMD functioning levels was administered the AAMD Adaptive Behavior Scale in the course of normal psychological assessments performed between 1982 and 1985. This data had been routinely collected from residential staff and had been used by psychologists for assessment and program planning activities previous to their use in the current research.

The AAMD Adaptive Behavior Scale is the most commonly used instrument for assessing daily living skills and behavioral development with the mentally retarded population. It surveys both adaptive and

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Continued from page 1

maladaptive behaviors, and derives percentile rankings with which to compare an individual client's skill development against norms available for an American sample of his/her institutionalized peers.

The available norms date from 1974, and thus are previous to the wave of deinstitutionalization which has swept North American public residential facilities during the last decade. The norms may thus not represent the current score profiles of the remaining institutionalized population, either because, say the "cream" of this population has been placed within the more normalized community residential environments which are now the preferred placements, or because new habilitative technologies are proving more effective in increasing client skill levels in the institutionalized population.

Summary and aggregate data was collated for each of three age groups similar to those reported in the 1974 ABS norms: Ages 19-29 (n=427); Ages 30-49 (n=518); Ages 50-69 (n=241). As well, an older subpopulation ages 70 plus (n=95) which had not previously been reported within the 1974 stratified norms was surveyed.

Norms for individuals below the age of 19 were not attempted because of the very small number of such individuals at the institution. As well, the very lowest functioning individuals at the institution were not surveyed in this present study, chiefly because their profoundly multiply handicapped levels prevented reliable differentiation within an ABS profile and because different assessment instruments were typically used within this population.

Within each age group, mean ABS scores for each adaptive and maladaptive behavior domain were calculated, and percentile rankings for each domain within each age group were derived. This calculation of percentile rankings allowed for direct comparisons with the 1974 AAMD-ABS norms.

It was hypothesized that the approximately 10-year period of desinstitutionalization and repatriation of clients would have reduced the average levels of adaptive behavior skills in the institutionalized population to levels below those reported in the 1974 norms. As well, it was also suspected that the average frequency of maladaptive behaviors in this population would increase relative to the 1974 norms. These two hypotheses were generally confirmed within the constraints resulting from comparing separate populations across time and national boundaries.

While more specific conclusions cannot be drawn from the available date, anecdotal and impressionistic evidence suggests that the process of deinstitutionalization has removed higher functioning and better behaved clients from large public residential facilities, leaving more dependent and problematic clients behind. The implications for resource allocation and service delivery to this remaining population are clear and self-evident, suggesting increased and specialized, rather than decreased and generic, service delivery provisions.

Further research is still needed to derive norms on daily living skills in the population of mentally retarded individuals who have more independent training services. Such research and data collection is required for standard MIS, evaluation, audit, and case management purposes. Finally, continuity of care concerns would suggest the need to track client adaptive behavior skills over time as they pass from more institutional to more independent environments in order to determine the effectiveness of deinstitutionalization and to ensure that clients continue to receive specialized habilitative care services appropriate to their needs and abilities.

Suicide Prevention in Rural Areas

Survey of Hinton Teens Regarding Suicide

G. Carter, RPN
Mental Health Services Clinic
Hinton. Alberta
Ph: 865-8247 (132-8247)

In February, 1985, I became increasingly alarmed with the high number of referrals our mental health office was getting on teen suicide. I believed that part of prevention is public education. So, I approached two high school counsellors. A public education program utilizing teens and parents was developed hoping to reach a larger target audience.

Planning began in the spring. The first meeting was held in November of 1985. Sixty-five parents appeared at our first meeting. From this meeting we had fifteen persons make a commitment to do volunteer work for the group.

Our first goal was forming a non-profit society and applying for public education funding. The Hinton Community Services (FCSS) were solicited.

Realizing we needed to know about the teens in our community to meet their needs with public education, a questionnaire was created utilizing information from Smokey Lake, and Dr. Ron Dyck, the Provincial Suicidologist.

A survey approved by the high school principal was presented to students in grade eight to twelve who wished to participate. Four hundred students that were present in school that day participated in the survey.

From the survey we learned the following:

- 48.7% of the teens have contemplated suicide
- 52.1% of these teens shared their suicidal thoughts with someone
- 60.8% of the teens knew someone who had contemplated suicide
- 67.9% of the teens knew someone who had completed suicide
- 64.4% of the teens would use a 1-800 telephone number to call the AID line in Edmonton, when distressed if this was available
- 96.1% of the teens did not know the Suicide-Distress phone number in Edmonton
- teens would prefer to be able to get educational material from the school library and the town library.

Many common myths of suicide were believed by teens. Some of which were (in order of popular belief):

1. People who commit suicide are depressed.
2. Improvement in emotional state means lessened risk of suicide.
3. Suicide among the elderly is rare.
4. Suicide is generally committed without warning.
5. Discussing suicide with a depressed person is dangerous because it puts the idea into his head.
6. Suicidal people indicate clearly that they want to die.

It was learned that teens knew of the following places to go for help and information regarding suicide: (in order)

- School counsellors
- Mental Health Services
- Family Life Center
- RCMP
- Hospital
- Minister
- Family doctor

The results of this survey were used to know where to place educational materials.

→

Client Confidentiality

Consent for Evaluation of Services

Hans Neidermayer
Clinical Director/Research Coordinator
Peace River Clinic, Mental Health Services
Northwest Region
Ph: 624-6151 (120-6151)

Research and evaluation activity in the Northwest Region led to expressions of concern by professional staff of the ethics of service (client and therapist) evaluation without the prior written consent of service recipients. Researchers/service evaluators have assumed that informed consent at the time of evaluation was sufficient to meet ethical guidelines.

Professional staff pointed concern to the extra-sensitive nature of mental health interventions, client-professional relationships, and the potential for abridgement of client rights to privacy of person, confidentiality of information, etc.

In order to address these concerns, a decision was made to request written consent from all registered clients early in the process of client contact — specifically at registration.

The Alberta Mental Health Management and Planning System (AMHMPS) was used for entry of client responses, beginning January 1, 1987, which had been succinctly requested via a brief form (Appendix 1) attached to clinics' forms. Entry to AMHMPS used one of four available optional fields on the Registration Form.

Regional and team summaries for 1987 are given in Table 1.

Two features of the results stand out. One, the rate of refusal, opting out, or abstaining was not insignificant, ranging from 29.5 to 54.8 percent of all clients registered, with a regional average of 35.8 percent. Two, the rate of client non-compliance: (no response obtained) was variable, ranging from 0.40 to 25.6 percent, with a regional average of 21.8 percent.

The results are provocative in suggesting that nearly one-half of all registered clients seen by Mental Health Service, Northwest Region, prefer not to be contacted in future for evaluation of services, or could/would not state a preference regarding the possibility of service evaluation. Interestingly, the data suggest that noncompliers (non-responders) would not consent if they did respond.

Current or proposed service evaluations will need to address the implications and issues posed by these findings. The current procedure for obtaining client consent to be involved in service evaluation will be maintained.

Table 1
Client Consent for Future Evaluation

TEAM	YES	NO	UNKNOWN*	TOTAL
1	299 (55.8%)	158 (29.5%)	78 (14.5%)	535
2	107 (42.2%)	81 (32.0%)	65 (26.5%)	253
3	233 (53.6%)	199 (45.8%)	2 (0.4%)	434
REGION	639 (52.2%)	438 (35.8%)	145 (11.8%)	1,222

* No Client Response Obtained

Appendix 1
Consent Form
Evaluation of Services

We would appreciate receiving your consent to contact you in the future for assistance in evaluating our service. You have the option to say "No" to possible contact.

If you are under 18 years of age at this time you should know that you are able to decline contact at any time in the future.

Please mark here if you consent _____

Please mark here if you do not consent _____

_____
Client/Parent/Guardian Signature

Many books and videos on teen suicide have been purchased and these can be borrowed by any group. An educational process of our members has continued. However this is moving slowly as we also have full time jobs and families and do not want to exhaust our resources. The time spent on this program is not enough.

Goals accomplished to date:

- Some community education
- button for teens ..."Life ... Love it ... Live it!"
- attendance at a Gatekeepers conference for further education
- development of a brochure specific to the warning signs of teen suicide
- by-laws, non-profit society
- scholarship for those pursuing studies in the helping professions
- fund raising
- trade show and agency fairs attendance
- distribution of educational material

Working with these keen teens and the high school counsellors has been a rewarding and difficult experience. There is still so much to be done with limited resources and time we have. Volunteers and finances are sadly lacking.

Conference announcements

1. Seventy-Eighth Annual Meeting of The American Psychopathological Association jointly sponsored by the University of Pittsburgh, School of Medicine, Department of Psychiatry will be held in New York City from March 3-5, 1988.
Topic: ***"The Validity of Psychiatric Diagnosis"***
Contact Person: Ellen Frank, Ph.D., of Western Psychiatric Institute and Clinic, 3811 O'Hara Street,
Pittsburgh, Pennsylvania 15213.
Registration Fee: Members $10, Non-members $75, Students $25
Location: St. Moritz Hotel, 50 Central Park South, New York City. Ph: (212)755-5800.
(Dr. Roger C. Bland, Assistant Deputy Minister of AMHS and Dr. S. Newman, Epidemiologist, both from AMHS Head Office, will attend this meeting.)

2. XX Banff International Conference on Behavioral Science will be held from March 20-24, 1988.
Topic: ***"Behavior Disorders of Adolescence: Research, Intervention, and Policy in Clinical and School Settings"***
Contact Person: Catherine M. Hardie, Director of Conference Services, Ph: (403) 762-6205
Registration Fee: $215 till Feb. 15 and $245 after that.
Location: The Banff Centre, Banff, Alberta
Ph: (403) 762-6205
(Dr. Ronald J. Dyck, Provincial Suicidologist, AMHS Head Office will address on the issue

continued on page 4

Recent additions to the Alberta Mental Health Services library

1. *The Alberta Mental Health Management and Planning System*
K.L. Walsh, H. Borowski and F. Langer
Head Office, 427-2816

2. *Ethical Standards for Therapeutic Programs in Human Services: An Evaluation Manual*
L. MacDonald
C.B.S. Edmonton, 427-2065

3. *Survey of Hinton Teens Re: Suicide: Suicide Prevention in Rural Areas*
G. Carter (Mental Health Clinic, Hinton)
Edmonton Region, 865-8247 (132-8247)

4. *Young Offenders, Child Welfare and Mental Health Caseload Communalities*
(In press: Canadian Journal of Criminology).
A.H. Thompson
Head Office, 427-2816

5. *Alcoholism in Alberta, Canada*
R.C. Bland, S. Newman and H. Orn
Head Office, 427-2816

6. *Mental Health 2000: Environmental Analysis*
J.M. Provencher
Edmonton Region, 427-4444

7. *Mental Health 2000: Analysis of Needs*
J.M. Provencher
Edmonton Region, 427-4444

8. *Mental Health 2000: Essential Resources*
J.M. Provencher
Edmonton Region 427-4444

9. *Odd Ratio Estimation in a Steady-State Population*
(Printed in the Journal of Clinical Epidemiology, Vol I, P.P. 59-65, 1988; in Great Britain)
S. Newman
Head Office, 427-2816

10. *Post-Traumatic Support-Groups with Tornado Survivors*
Presented at Canadian Group Psychotherapy Association Annual Conference, 1987
R. Winnick
Edmonton Region, 427-4444

11. *AMHMPS: A Source of Research Data*
H.Z. Borowski
Head Office, 427-2816

12. *Overview of Strategic Planning Process*
J.M. Provencher
Edmonton Region, 427-4444

13. *Crisis Initiated Intervention: A Proposed Pilot Project for Slave Lake*
Mental Health Services
P. Haines
Northwest Region, 849-7297 (121-5160)

14. *Patient Rights, Professional Ethics and Situational Dilemmas in M.H. Services*
J.L. Pettifor
Calgary Region, 297-7509 (161-4529)

Recent publications by departmental staff

1. Newman, S; Dyck, R.
On the Age-Period-Cohort Analysis of Suicide Rates. (This paper due to appear in "Psychological Medicine," discusses some of the interpretive problems arising out of birth cohort analysis, a method that is increasingly being applied to suicide data.)
AMHS Head Office, 427-2816

2. Newman, S; Bland, R. and Orn, H.
A Comparison of Methods of Scoring the General Health Questionnaire. (This paper, due to appear in "Comprehensive Psychiatry," demonstrates, using data from the Edmonton Survey of psychiatric illness, that a recently proposed method of scoring the GHQ which was designed to detect chronic symptoms offers no advantage over the traditional Goldberg approach.)
AMHS Head Office, 427-2816

3. Thompson, A.
Young Offenders, Child Welfare and Mental Health Caseload Communalities
(In Press: Canadian Journal of Criminology).
AMHS Head Office, 427-2816

Conference announcements cont'd from page 3

"Suicide and the Young: Implications for Policy and Programming".)
Dr. Ronald Dyck will also address the Teachers' Conventions in Edmonton and Medicine Hat on Feb. 25 and Feb. 26 on the topics ***"Children — The Stressers or the Stressed"*** and ***"Schools' Role in Suicide Prevention"*** respectively.

3. PHMAC Research Committee will hold 1988 Alberta Mental Health Research Conference on March 24, 1988.
Topic: ***"Disabling Chronic Anxiety Disorders"***
Contact Person: Dr. Ronald J. Dyck, Provincial Suicidologist and Executive Secretary of the PHMAC Research Committee.
Ph: 427-2813 — AMHS, Head Office Edmonton
Registration Fee: Nil
Location: McCall Room, Chateau Airport Hotel, Calgary, Alberta
(Dr. A. H. Thompson, Sr. Psychologist and the Director of Research and Evaluation Unit, AMHS Head Office, will present a paper ***"Anxiety Disorders in Children."***)

4. Alberta Regional Conference of the Canadian Evaluation Society will be held April 24-26, 1988.
Topic: ***"Use & Misuse of Evaluation: A Guide for Consumers and Evaluators"***
Contact Person: Dr. Gary Bernfeld, Chairman of the Conference Planning Committee. C/o Information and Evaluation Department, William Roper Hull Home, 117 Woodpark Boulevard SW, Calgary, Alberta.
Ph: (403) 281-2266
Location: The Lodge at Kananaskis, West of Calgary, Alberta

RESEARCH & INFORMATION
MENTAL HEALTH NEWSLETTER

is published quarterly by the Mental Health Research Unit and distributed to Departmental employees interested in research issues and related information.
A/Editor: Vipin Sharma

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Alberta
COMMUNITY AND OCCUPATIONAL HEALTH

Volume 3 Number 2 Fall 1988

RESEARCH & INFORMATION

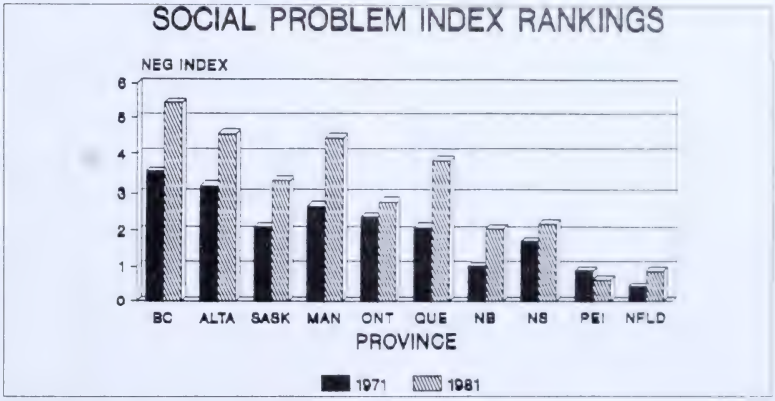
MENTAL HEALTH NEWSLETTER

Social Problems and Mental Illness

Social Problems, Westerly Trends, and Social Climate in Canada

A.H. Thompson, Ph.D., C.Psych.
Director of Research and Evaluation/
Senior Psychologist
Alberta Health
Mental Health Division (Head Office)
Ph: 427-2816 (147-2816) and
Andrew Howard
Faculty of Medicine
Queen's University

Data on a variety of social problems were collected for each of the ten Canadian provinces for 1971 and 1981. The eight problems for which rates were derived were homicide, attempted murder, assault, rape, robbery, divorce, suicide, and alcoholism. A factor analysis indicated that approximately 65 percent of the variance among these eight scores could be accounted for by a single factor. Thus, a single "negative index" was constructed that represented a composite of the eight component social problem scores.



These results showed a dramatic increase in the negative index as one moves from the East to West in Canada. This is depicted in the accompanying figure. Note

continued on page 2

Introduction

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If you feel you have an article which you think should be included in the newsletter, please submit a summary of your work (maximum 1000 words).

Dropping Out of Psychiatric Treatment

A Retrospective Study of Dropout Rates from a Community Mental Health Centre and Associated Factors

D.M. Romney, Ph.D.
Professor, Faculty of Education
The University of Calgary

T.A. Jose, Ph.D.,
Director of Psychology/
Research Co-ordinator
A.M.H.S. Calgary Region
Calgary Ph: 297-4520 (161-4514)

Published in:
Canada's Mental Health, March 1988

Dropping out prematurely from psychiatric treatment is a serious problem: it is not in the interests of the client, it has a demoralizing effect on the therapist, and it is costly for the agency. Furthermore, insofar as dropping out is an index of dissatisfaction with services, the agency may lose the confidence and patronage of the community (Pekarik, 1985). Reasons given by clients for premature termination of treatment are very diverse, ranging from lack of spare time to dislike of the therapist (Romney, 1986); however, the mere fact

continued on page 2

Social Problems and Mental Illness, continued from page 1

that not only does the general social problem rate increase from East to West, but also that the figures are higher in 1981 than in 1971.

A number of sociodemographic factors showed high correlations with the negative index. The following factors had a particularly high positive correlation with the negative index: small household size, a high proportion of university graduates, a large proportion of nonreligious individuals, high personal income, high levels of migration, a large proportion of the population living in urban centres, and high levels of ethnic variability. Regression analyses showed that the use of three of these factors for 1971, and five for 1981, accounted for well over 90 percent of the provincial differences in the negative index.

The evidence in the literature indicates a strong association across individuals between social problems and mental illness (i.e. the mentally ill are much more likely to exhibit social problem behavior). However, this association does not appear to hold true across provinces. That is, what little evidence there is suggests that the rates of mental illness do not vary to any great extent. This supposed discrepancy between variation in rates of mental illness and social problem points to further examination of some old views on the way in which social climate and mental illness interact to provide social problem behaviors.

Dropping Out of Psychiatric Treatment, continued from page 1

that services may not be easily accessible to those most often in need, i.e., the lower socioeconomic strata, may deter them from using these services (Fraps et al., 1982).

To ascertain if decentralization of mental health services, making them more accessible to the public, would be reflected in a decrease in drop out rates, a comparison was made between dropout rates just prior to and immediately following decentralization of Alberta Mental Health Services Calgary Region. This involved examining 1350 closed files representing cases seen during a three-year period after decentralization, (December 31, 1983 – November 1, 1986) and comparing the findings with those of a previous study of files of 588 cases seen during a year before decentralization (May 1, 1978 – April 30, 1979).

Salient Findings

1. The dropout rate is high (43%) but is nevertheless comparable to dropout rates found in similar studies.
2. There has been a small (3%) but statistically significant (chi square = 21.91, p<.001) decrease in the dropout rate since 1978-79. As many as 11% fewer clients decline further therapy but this improvement is offset by 6% more clients withdrawing without notification and about 2% more not appearing for treatment (see Table 1).
3. There is a curvilinear relationship between dropping out and age, peaking between ages 13–18 (59%) and 19–29 (51%). The lowest dropout rate (10%) is for senior citizens.
4. The dropout rate is not affected either by the sex of the client (chi square = .36, p = .55) or by the sex of the therapist (chi square = .05, p = .81).
5. Overall, there is an inverse relationship between dropping out and level of education. Thus, 50% of clients who received only elementary education dropped out as opposed to 32% who went to college or university.
6. Similarly there is an inverse relationship between dropping out and occupational status, e.g. 50% of labourers dropped out compared with 28% of managers. Moreover, the dropout rate is much higher (58%) for those who rely on unemployment insurance or public assistance for their income than for those who are self-supporting (41%), dependent on family (42%) or receive pensions (15%).
7. Clients who refer themselves (about a third of all referrals) or who are referred by family or guardian drop out more (47%) than medical referrals (35%).
8. Rank ordering dropouts by diagnosis indicates that the clients most likely to drop out are those diagnosed with personality disorder (68% of 101), followed in turn by adjustment reactions (40% of 432), neurotics (37% of 123) and acute reactions (30% of 37). There were too few cases in other diagnoses to have confidence in the results.
9. Most (70%) of those clients who drop out do so within five visits to the clinic and 58% of dropouts do so during the first month.
10. Clients who are given a treatment plan are less likely to drop out than those who are not (39% vs. 49%).
11. The drop out rate varies with the individual therapist. For instance, as few as 10% (of 40) dropped out from one therapist whereas 73% (of 60) dropped out from another.
12. There was a clear inverse relationship between dropping out and the effectiveness of treatment so that the more effective the treatment the less the likelihood of dropping out. The following correlation coefficients were derived for the different forms of treatment:

counselling	r = -.40	(n = 404)
psychotherapy	r = -.51	(n = 248)
marital therapy	r = -.51	(n = 82)
family therapy	r = -.44	(n = 148)
play therapy	r = -.48	(n = 63)

13. Considering dropouts alone, 33 clients (72%) who were separated and 8 clients (80%) who were widowed dropped out after attending fewer than four sessions.

Table 1. Breakdown of Closed Cases (Held 1978–79 Figures in Parentheses)

Reason for termination	Absolute frequency	Relative frequency	
Terminations by clients	727	53.9	(65.3)
Never appeared for treatment	111	8.2	(6.5)
Withdrew without notification	367	27.2	(21.3)
Declined further treatment	104	7.7	(18.7)
Moved from region	91	6.7	(9.7)
Transferred to another agency	44	3.3	(8.5)
Deceased (suicide)	1	.1	(0.2
Deceased (other)	9	.7	(0.5)
Terminations by therapists	617	45.7	(34.5)
Mutual agreement	535	39.6	(30.8)
Terminated	6	.4	(0.2)
Referred elsewhere	76	5.6	(3.6)
Not specified	6	.4	(0.2)
Total	1350	100.0	(100.0)

NOTE: The first three categories signify dropouts.

Announcements

1. James Vargo, Editor-in-Chief, Divisional Editors Steven Dennis, John Semple and Don Bevan of the new Canadian Journal of Rehabilitation/Revue Canadienne De Réadaptation presented a commemorative copy of the Journal's premier issue (Mar/April, 1988) to the Wild Rose Foundation.

The Wild Rose Foundation, created by the Government of Alberta, supports individual projects and volunteer, non-profit organizations through grants from Western Canada Lotteries revenue.

The Foundation awarded financial assistance of $30,000 to the Journal. Additional funding was provided by the University of Alberta's Faculty of Rehabilitation Medicine and by the Western Industrial Research and Training Centres. The Journal, published quarterly by the Edmonton Rehabilitation, recognizes uniquely Canadian achievements as well as works of international interest.

Phone: (403) 454-9656.

2. **Suicide Prevention Training Programs**

Over the past few years, the Canadian Mental Health Association in Alberta has developed and implemented a unique training program aimed at professionals and other caregivers throughout the province. Administered by the Canadian Mental Health Association (CMHA), Alberta Division and sponsored by the Government of Alberta, the Suicide Prevention Training Programs Foundation Workshop has been utilized by over 6,000 Alberta caregivers, with more being trained each month. Qualified trainers, chosen for their teaching skills and suicide prevention experience, conduct the SPTP workshops in any Alberta community where a need for the training is required.

The two-day workshop focuses on areas deemed essential in suicide prevention:

- The attitudes of workshop participants toward suicide are explored. Participants discuss and identify the need to be aware of their own attitudes as these attitudes can affect their interactions with suicidal people. The current body of knowledge in suicidology is explored. In addition to discussing the various facts and myths related to suicide, clues to suicidal behaviour, factors of risk and statistical facets of this issue are explored.
- Intervention skills are developed and practised through a series of supervised interview simulations and role play exercises. Through trainer facilitation and group feedback, the dynamics of practical intervention are explored, identified and examined. Participants combine their own professional skills and knowledge with newly acquired knowledge to become more effective caregivers.
- Finally, there is the networking/ resourcing component. Participants brainstorm in order to identify all possible resources within their community. In this way, the Foundation Workshop provides an opportunity for community professionals and other gatekeepers to establish a variety of contacts and ideas which are useful for the development of a crisis intervention network. Workshop facilitators provide additional information about available suicide information and prevention resources. Each person who completes the Suicide Prevention Training Programs Foundation Workshop receives a certificate of attendance.
- The present goal of the Suicide Prevention Training Programs (SPTP) is to make suicide prevention training available to all Alberta caregivers through the Foundation Workshop. Future plans include the development of advanced and specialized components on adolescent suicide and bereavement.
- Requests for information can be directed to the Coordinator, Suicide Prevention Training Programs, #201, 1615 - 10th Avenue S.W., Calgary, Alberta, T3C 0J7. Phone: (403) 245-3900.

3. **Funding Announcements: Mental Health Research**

The National Health Research and Development Program (NHRDP) of Health and Welfare Canada recently made a special announcement directed to those with interests in mental health. The usual December 1st deadline for proposal submissions has been extended to February 1st, 1989.

The NHRDP is specifically seeking proposals to conduct research in the mental health field. Sample topic areas were outlined in the statement of scope for literature review, the general direction of which provides an outline of eligible research:

(1) Individual, group and environmental factors which contribute to or impact upon mental health;

(2) Individual, group and environmental factors which have a bearing on the distribution and occurrence of mental illness;

(3) Consumer participation in the design and delivery of services or programs for the mentally ill or for the promotion of mental health;

(4) Community based services or programs for the mentally ill or for the promotion of mental health;

(5) Measures and indicators of the mental health status of populations, from the perspective of their validity and power in identifying and estimating the contribution of group and environmental factors to mental health.

Further information on this call for proposals is available from Carl Lakaski, Acting Director, Mental Health Division, Health Services Directorate, Health and Welfare Canada, Ottawa, Ontario, K1A 1B4. Phone: (613) 954-8643.

4. Alberta Mental Health Services Symposium '88 was held in Lethbridge, Alberta on October 5 and 6, 1988. Congratulations to the South Region staff of Mental Health Services who worked hard for its success. Dr. Ray deV Peters (Department of Psychology, Queen's University) was the keynote speaker who gave a special presentation on the topic of "Mental Health Promotion and Community Involvement." Over 40 presentations (and workshops) were also given by researchers from all the Mental Health Regions and Head Office.

The main emphasis of the next issue of the Mental Health Newsletter will be devoted to the publication of abstracts/ brief summaries of the presentations mentioned above.

Mainframe Computer Files — ARIES

(AMHMPS Research, Information, and Evaluation Subfile)

H. Borowski
Manager, Policy Development,
Planning/Information System
Mental Health Division (Head Office)
Phone: 427-2816

ARIES is a series of mainframe computer files which can be used by regional researchers and planners to analyze data or to produce their own special reports. The files are accessible via AMHMPS (Alberta Mental Health Management and Planning System) terminals or micro-computers connected to the Government Computing Centre. The ARIES user should also have a basic familiarity with the Roscoe teleprocessing package and SPSSX programming language. Other programming languages can be used to analyze the data, but the user would have to write his or her own file definition.

ARIES Characteristics

The ARIES files have the following features:

- a master SPSSX (K9.ARIES) program has been written and is maintained for ARIES users. This model program can be modified relatively easily by users to produce their own reports. It contains the necessary file definition, variable names, and value labels needed to read the data files described below.
- seven separate files are produced. Each region will be able to work with a file containing only its own data. The seventh file contains information from all six regions and is for the use of researchers requiring provincial data.
- the files are created as GDG's (generational datasets). This means that users, through appropriate changes to their program JCL, can retrieve older versions of the files. the current month's file and those for the preceding two months will always be available to users.
- the files contain information from the current fiscal year and the previous two complete fiscal years. For example, a file created on August 10, 1988 would contain 1986-87 and 1987-88 data as well as data for the period April 1, 1988 to August 10, 1988.
- the files contain selected non-client identifying data from the activity level, i.e., contact detail is not provided on the file. Some contact related information — usually in a summarized form — is reported.
- the files are flat files, i.e., one record is created for every activity the client had during the period covered by the file.

File Access

The following is required to use the files:

- a Roscoe ID — if the region does not have any, one can be obtained by phoning the Manager, MHIS, 427-2816.
- ISD Account No. — each region has its own account number to which the cost of the computer runs is billed. **These costs are covered by the MHIS budget, and are not a regional expense.**
- ARIES Regional File Name
- some knowledge of Roscoe and SPSSX
- JCL needed to submit programs for processing.

Costs

MHIS will pay the computer processing costs from its budget. Although we do not have unlimited funds, no arbitrary limit has been set on the dollar value of usage that will be supported. Initially the costs are not likely to be high. Expenditures will be monitored from the perspective of cost effectiveness.

Separate regional files were created to minimize costs. As well, the expectation is that the majority of programs submitted by regional users will cost relatively modest amounts (programs costing over $5.00 should be the exception).

User Support

Training and support is provided jointly by the AMHMPS and Research and Evaluation Units of MHS, Head Office. Betty Schultz and George Stebelsky are the individuals principally responsible for user support. Betty is responsible for creation of the files and maintenance of the technical environment, while George provides orientation to Roscoe, JCL and basic SPSSX.

The expectation is that users are committed to learning to work with the files and are familiar with, at least, basic statistics. Preferably users will have had prior experience with SPSSX or some other reporting language. Unfortunately, we have insufficient staff to provide extensive instruction in SPSSX.

Variables Contained in ARIES

Client ID No.
Activity No.
Sex
Date of Birth
Postal Code
Referral Date
Registration Date
Age
Region No.
Team No.
Contact Hours
Post-termination
Contact Count
Waiting Period
Referral Source
Marital Status
Public Guardian

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cont'd from page 4

CWS History
CWS Status
Court Status
Local File No.
First Contact Date
Last Contact Date
Contact Total
Maintenance Status
Termination Date
Reason for Term.
Referral at Term.
Length of Stay
Optional Fields
Diagnoses (3)
Therapist Name
Therapist No.
Therapist Function
Therapist Discipline
Therapist's Working Location

Pros and Cons

Regional researchers, planners, and users will hopefully derive the following benefits from using ARIES:

- easy and ready access to AMHMPS clinic data;
- better report turn-around times because of local printing at AMHMPS on-line sites;
- more flexibility in report content;
- reports focussed to specific local needs;
- better understanding of the potentials and limitations of the information; and
- an enhanced and even more responsive information system through greater user involvement;

The disadvantages are:

- time commitment needed to learn ARIES and SPSSX. It is minimal to get started (one or two days), but it will be much more to develop an expert's competence;
- ARIES contains only a subset of information from AMHMPS;
- the environment is not the most user-friendly one (i.e., it's not menu driven, etc.).

Other Features

The experience with this file could potentially provide the basis for future down-loading of AMHMPS data to regional micro-computers once appropriate micro-computer software and hardware is widely available.

Researchers wishing to add data collected from client files or surveys should be able to use client numbers or local file numbers to merge files containing ARIES and their data to create a single file.

Recent Additions to the Mental Health (Head Office) Research Library

1. *The Structure of Society and Native Mental Health.* Presented at Health & Welfare Canada Conference "Exchanges in Indian & Inuit Mental Health."
   A.H. Thompson
   Head Office, 427-2816

2. *A Preliminary Outcome Study of a Community Group Treatment Program for Emotionally Disturbed Adolescents.* Can. J. Psychiatry, Vol. 31. March, 1986.
   M. Blackman; S. Pitcher and F. Rauch
   Edmonton Region, 427-4444

3. *Client Satisfaction Questionnaire — Calgary Region.*
   G. Gammon, J. Axelson and E. Grant
   Calgary Region, 297-4520 (161-4520)

4. *The Failure to Detect Organicity in Psychiatric Outpatients.*
   R.W. Kitchen
   Edmonton Region, 427-4444

5. *The Comparison of Recidivism Rates and Related Variables in Day Program and Non-Day Program Outpatients: A Stress Process Perspective.*
   J. Eustace and M. Johnston
   Edmonton Region, 427-4444

6. *Caseload Analysis Using a Nursing Model of Health Illness Phenomena.*
   G.H. Keller, C. Hutchinson and M. Munro
   Central Region, 340-5047 (151-5047)

7. *Recent Trends in Outpatient Services to Priority Client Groups.*
   H. Borowski
   Head Office, 427-2816

8. *Suicide Bereavement Needs Survey* (A Report Prepared for SPPAC & Management Board of Suicide Prevention Training Program).
   D. Beaman, R.J. Dyck and W. Hunter
   Head Office, 427-2816

9. *Skin Conductance and Cardiovascular Responses of Infrequent Panickers and Non-Panickers to Threat of Shock.*
   D.L. Ramsum
   Graduate Program
   University of Manitoba

10. *Family Violence and Its Relationship to Treatment Variables at AMHS Edmonton Region.*
    B. Walker
    Edmonton Region, 459-2820

Recent Publications by Mental Health Services Staff

1. Bland, R.C. and Kolada, J.
Diagnostic Issues and Current Criteria for Schizophrenia.
Handbook of Schizophrenia; Vol. 3: Nosocology,
Epidemiology and Genetics (Ch. I)
Head Office, 427-2816

2. Hezler, J; Canino, G; Hwu, H; Bland, R; Newman, S; and Yeh, E.
Alcoholism: A Cross National Comparison of Population Survey with Diagnostic Interview Schedule.
Origins and Outcome. Raven Press; New York, 1988.
Head Office, 427-2816

3. Bland, R.C.; Newman, S.C. and Orn, H.
Prevalence of Psychiatric Disorders in Edmonton.
Alberta Psychology, Vol. 17, No. 1 Jan/Feb 1988.
Head Office, 427-2816

4. Bland, R.C.
Prevalence of Mental Illness
Update Psychiatry — Annals RCPSC, Vol. 21, No. 2, March 1988
Head Office, 427-2816

5. Jose, T.A. and Romney, D.M.
A Retrospective Study of Dropout Rates From a Community Mental Health Centre and Associated Factors.
Canada's Mental Health, March 1988.
Calgary Region, 297-4514 (161-4514)

6. MacDonald, L.
Improving the Reliability of a Maladaptive Behavior Scale.
American Journal of Mental Retardation, 1988, Vol. 92, No. 4, 381-384.
C.B.S.; Edmonton, 427-2065.

7. Barnsley, R.H. and Thompson, A.H.
Birthdate and Success in Minor Hockey: The Key to the NHL.
The Canad. J. Behav. Sci.
20(2), 1988. Pp. 167-176.
Head Office, 427-2816

8. Dyck, R.J.; Newman, S.C. and Thompson, A.H.
Suicide Trends in Canada
Acta Psychiatrica Scand. 1988: 77: 411-419.
Head Office: 427-2816.

9. Kitchen, R.W.
Treating Caregivers of Alzheimer's Patients.
Geriatrics, June/July 1988; pp. 53-63.
(Department of Psychiatry, U of A, Edmonton)
Edmonton Region, 427-4486

Recent Projects Approved by the Alberta Mental Health Services Research and Ethics Review

1. Mortality in Child Welfare Wards.
A.H. Thompson
S. Crocker
Head Office, 427-2816

2. Community Reactions to the Deinstitutionalization of Psychiatric Patients.
Profs. B. Hall & D. Collins
University of Calgary, Faculty of Social Welfare, Lethbridge Division
South Region, 181-5329

3. Survey of Mental Health Care Services Utilization in Edmonton
S.C. Newman
Head Office 427-2816

4. Prevalence of Psychopathology in Children With Child Welfare Status
A.H. Thompson
P. Campbell
Head Office, 427-2816

5. Efficacy, Outcome and Alcohol Effects Expectancies — As Predictors of Alcohol Treatment Outcome: An 18-Month Follow-Up Study.
Joy Thompson
AADAC, 427-4275

6. CMHA Needs Assessment Study of the Mentally Ill.
Joanne Zaborowksi
CMHA
Lethbridge, AB.

7. Environmental Evaluation of Starholm Residence
Bill Johnston
South Region, 181-5329

8. The Evaluation of Individual and Group Therapy of Suicide Patients in the Adult Assessment and Treatment Program.
R. Winnick
L. Kalynchuk
Edmonton Region, 427-4444

9. The Relationship Between the Circumplex Model of Interpersonal Behavior and Personality Disorder.
Jordan Sim
Graduate Program
University of Calgary, 220-5700/220-5662

10. Edmonton Health Attitude Study
A.H. Thompson
P. Campbell
Head Office, 427-2816

RESEARCH & INFORMATION
MENTAL HEALTH NEWSLETTER

is published quarterly by the Mental Health Research Unit (Head Office) and distributed to departmental employees interested in research issues and related information.
Editor: Vipin Sharma

If you require additional copies of the newsletter, or know of any individual or group that would like to receive future issues, please call 427-2816 or write to the Director of Mental Health Research and Evaluation, 4th Floor, Seventh Street Plaza, 10030 - 107 Street, Edmonton, Alberta, T5J 3E4.

Alberta HEALTH

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RESEARCH & INFORMATION

MENTAL HEALTH NEWSLETTER

Conference Presentation Summaries

Family Violence and Mental Health Treatment

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Edmonton Region
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In the early months of 1986, at a time when inquiry into family violence was not common among therapists in the Edmonton Region, two sources of influence came to bear in drawing our attention to the possibility of family violence as an important variable in the treatment of clients at Alberta Mental Health Division. The first of these influences was a growing awareness on the part of a few therapists who were finding increasing indications of family violence in the lives of people on their caseload, especially in the rural area of the Edmonton Region. A second influence was the epidemiological work done by Bland and Orn (1986) which suggested that violent behavior, both within the family and outside the family, has a strong relationship to psychiatric disorder.

In undertaking this study, we hoped to gain a better understanding of both the prevalence of family violence in the lives of our clients, and its possible effect on our treatment of these clients.

Data regarding family violence was sought by each therapist for each client seen initially between July 1, 1986 and June 30, 1987. The data were coded by the therapists into five digit numbers according to the following categories:

1st digit identified victims as:
1 - abused child,
2 - abused spouse,
3 - adult abused as a child,
4 - abused elder,
5 - more than one of the preceding,
0 - no abuse elicited;

2nd digit identified perpetrators of:
1 - child abuse,
2 - spouse abuse,
3 - elder abuse,
4 - more than one of the preceding,
5 - no abuse elicited;

3rd digit identified the type of abuse as:
1 - physical/emotional,
2 - sexual/emotional,
3 - emotional only,
4 - physical/sexual/emotional,
9 - no abuse elicited;

4th digit identified the length of time since the last incident as:
1 - 0 to 3 months,
2 - 4 to 12 months,
3 - 1 to 5 years,
4 - more than 5 years,
9 - no abuse elicited;

5th digit identified disclosure of family violence as:
1 - by referral source,
2 - by client during assessment or treatment,
9 - no abuse elicited.

The "family" in family violence was broadly defined to include relationships such as spouse, parent, grandparents, aunts, uncles or in-laws, but specifically excluded other trusted caregivers such as babysitters or teachers. The "violence" was likewise broadly defined as acts that endangered the survival, security, or development of the victim: physical acts such as hitting, choking, or intentional inflicting of pain; sexual acts forced upon or demanded of a reluctant partner such as group sex, anal sex, or penetrating objects; emotionally abusing acts such as name-calling, threats, or destruction of property which occurred without accompanying

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Introduction

The Research and Information Newsletter is published by the Mental Health Research Unit in order to make it possible for departmental individuals and groups to keep abreast of current research and information related to mental health and other departmental programs.

The newsletter will present abstracts or summaries of selected relevant articles or papers produced by departmental staff. These will include new projects, published or unpublished papers, conference presentations, as well as research news.

If you feel you have an article which you think should be included in the newsletter, please submit a summary of your work (maximum 1000 words).

The Alberta Mental Health Symposium '88 was held in Lethbridge, Alberta on October 5 and 6, 1988. Presentations were given by researchers from all the Mental Health Regions and Head Office. This issue is devoted to the publication of abstracts/brief summaries of some of the presentations.

Conference Presentation Summaries, continued from page 1

physical or sexual abuse. Emotional abuse was assumed in situations where physical or sexual abuse was reported. Because children are not old enough to give consent, they were considered as a victim of sexual abuse in a relationship with an adult when their personal privacy was violated, or when fondling or intercourse took place.

An example will serve to illustrate the coding procedure: a 39 year old woman, self-referred for treatment of depression, who subsequently disclosed intercourse with her father in her family of origin would be coded 39242; should this woman, in addition to the preceding information, disclose that she had locked her child in the closet last week to stop his screaming, she would receive a code of 31412. The first code identifies her as a victim of sexual abuse long-ago, while the second code identifies her as both a victim and a perpetrator, involving both physical and sexual abuse, with the most recent incident occurring within the last three months. The family violence code for each client was marked in an optional field on the termination form by the therapist as part of the usual termination procedure. This code was subsequently entered into the Alberta Mental Health Management and Planning System (AMHMPS) by an on-line data operator, along with routinely collected client information such as age, diagnosis, treatment, contacts, and so on. Family violence data can thus be related to a wide variety of client and treatment variables, and analysis can be carried out from any data entry terminal once official clearance has been obtained.

Family violence was reported in 35% of the clients seen by the Suburban/Rural Program, 33% of those seen by the Adult Assessment and Treatment Program, 17% of the clients seen by the Community Rehabilitation Program, and 7% of the clients seen by the Geriatric Psychiatry Program. The therapist reporting range showed even greater variation, with some therapists reporting no family violence in any client during the year, and one therapist reporting that 79% of her caseload had a history of family violence.

Data is available on 3260 clients, of which 680 or 21% were identified as victims only, 162 or 5% were victim/perpetrators, and 79 or 2% were perpetrators only. A cross tabulation of these groups by current primary diagnosis indicates that all family violence groups are over-represented in the diagnostic categories of 302 Sexual Disorders and under-represented in the diagnostic categories of 290-5 Psychosis and 297 Paranoid States. Both victim/perpetrators and perpetrators only were over-represented in the diagnostic categories of 312 Conduct Disturbance and 304-5 Drug Dependence/Abuse, while victim/perpetrators are diagnosed more often as 301 Personality Disorders. Victims only are over-represented in the 308 Acute Stress Reaction category.

Analysis of the victim only data indicates a prevalence of sexual abuse, with 58% of the abused children, 67% of the adults — abused as a child, 58% of the abused spouses, and 85% of the adults — abused as a child/abused spouse group reporting sexual abuse, with or without physical abuse.

Analysis of the perpetrator only data indicates that 18% of the perpetrators were abusive to their children only, 63% to their spouses only, 13% to both their spouses and their children, and 6% to their elders. Of the abuse perpetrated on children, 64% was sexual; for that perpetrated on spouses only, 59% was physical; and for the combined child and spouse victim group, 60% of the abuse was both physical and sexual.

The victim/perpetrator in our study has been subject to the abuse of another family member at some time in their life, and has also inflicted abuse on another family member. Analysis of the type of victim by type of perpetrator yields the following: the abused child who is also a perpetrator, is most likely to inflict abuse on another child; likewise, the adult abused as a child is most likely to inflict abuse on a child; the abused spouse is most likely to inflict abuse on a spouse; and the abused spouse/adult abused as a child is most likely to inflict abuse on both a child and a spouse. While these findings suggest that people do onto others what has been done to them, this applies *only* to those who are both victims and perpetrators. There were many victims in our study, and only a small percentage were also identified as perpetrators as is illustrated by the following ratios: only one in seven abused children was also identified as being a perpetrator of family violence; one in four adults — abused as a child was likewise identified; one in six abused spouses was also a perpetrator of family violence; and one in three people identified as being both an abused spouse and an adult abused as a child was also identified as a perpetrator of family violence.

An analysis of family violence groups by sex of the client reveals the not surprising finding that males outnumber females ten to one in the perpetrator only category, while females outnumber males five to one in the victim only category. The victim/perpetrator category was fairly evenly split between males and females.

Global Functioning Scores were compiled for each client seen initially during the year of this study. These scores form the basis of Axis V on the Diagnostic & Statistical Manual of Mental Disorders — third edition, revised (DSM III R) and represent the judgement of the therapist as to the psychological, social, and occupational functioning of their client, on a scale from 1 to 90 as compared to criteria provided for each level (i.e., 1 to 10, 10 to 20, etc.). The scores upon termination were compared with those at assessment using a t-test of the significance between means. Significant differences (increases) were found in five diagnostic categories for victims only — Other Family Circumstances, Neurotic Disorders, Alcohol Dependence, Acute Stress Reaction, and Adjustment Reaction. For the victim/perpetrator group, only two diagnostic categories showed significant improvement — Adjustment Reactions, and Child Emotional Disorder. Within the perpetrator only group, only one diagnostic category showed significant improvement (Sexual Disturbances) while several diagnostic categories showed decreased scores at termination, although these decreases were not statistically significant.

The data above leads to the following conclusions:

1. The incidence of family violence in the lives of our clients is high enough to suggest that all therapists must become proficient in identifying this variable in order to effectively treat their clients.
2. The vast discrepancies between therapists in reporting family violence in the lives of their clients suggest to me, that the true incidence of family vio-

continued on page 3

Conference, cont'd from page 2

lence is higher than the 28% reported in this survey. Other studies have also identified under-reporting of family violence by treatment personnel in other settings.

3. As a group, the victims only are most likely to benefit from our treatment as measured by changes in the Global Functioning Scores from assessment to termination — the perpetrators only are the least likely to benefit using this indicator.
4. The optional field has demonstrated its usefulness in collecting considerable amounts of information which can then be analyzed in terms of routinely collected client data.
5. Much of the data from this study remains unanalyzed at the time of writing. Further analysis is anticipated, including individual file analysis of specific types of family violence clients.

Excellence Within Reason — A Socialization Group for the Chronically Mentally Ill

Edna Jolly, R.N.
Stettler, Alberta
Ph: 742-7591
and
Phebe Cotterill, M.S.W.
Stettler, Alberta
Ph: 742-7591

A major concern in the de-institutionalization of long-term psychiatric patients is the quality of life experienced in returning to a community environment. Our objective as rural mental health therapists has been to enhance life opportunities and teach socialization skills while restoring and preserving mental health.

To implement these goals, our Alberta Mental Health Services clinic has established a unique therapy group. Eligible participants are clients with long term illnesses including manic depression, schizophrenia and the psychotically depressed, most of whom have had multiple hospitalizations.

During the one and a half years of the group's existence, many benefits have emerged for its members. These include acceptance of self and others, support systems which function independently of group sessions, participation in community activities, establishment of appropriate group norms and behaviors by the members themselves, and a celebration of what is positive in their lives.

Non-acceptance is a key issue for our clients. The fostering of a sense of fun and humor has greatly lessened the impact of this stigma and allowed them to recognize and develop their own potential — many for the first time in their lives.

Therapist issues and participation were also discussed.

Possibilities for Group Work with Abused Women

Yvonne Sell, B.Th., S.S.W.
Social Worker
Edmonton Region
and
Karin Dobranski, R.P.N.
Community Nurse
Edmonton Region
Ph: 427-4444

Philosophy

a. All family members have a right to live without violence in their family.
b. Perpetrators are responsible for their own violence.
c. Violence is not an appropriate method of solving problems.
d. Appropriate and effective intervention is critical to all individuals involved in the community at large.
e. The community must be involved in a provision of service, the examination of values and the acknowledgement that wife abuse is both debilitating and criminal.

Type and Structure of Group

We call our group Women in Abusive Relationships and our criteria is any woman who currently is or has been in an abusive relationship. This covers all types of abuse.

It is a twelve week, two hours a day, closed group.

A psychoeducational group plus explanation.

Pre-group screening and why. For an example, in the first group we did not do any screening as we were rushed into it and ended up with one woman who was totally inappropriate for the group. As well, we had many drop-outs.

We do like to check for depression and see what are the diagnoses that have been given. No suicidal or psychotic patients are allowed in the group and we prefer only to have a few borderline people in the groups as they can be quite disruptive.

We administer the Bech Di pre and post group and may be starting some other questionnaires as well and we hope eventually to gather enough data to begin to develop a more comprehensive picture of the women we serve.

Our Goals

Insight — to help them accept the reality of the situation — we have abuse questionnaires that we use.

- Also to help them understand the decisions they need to make.
- Characteristics of abuser and abused.
- Whether to stay or leave.
- How to be safe (check-in, legal issues, financial issues).
- Help them be aware of their rights as a person.
- Self-esteem and confidence — help them develop that and methods of achieving same.
- How to use anger constructively — not just men bashing.
- Children's issues — prevention — how to stop the cycle.

Our Methods

1. The sharing — not alone in situation.
   - It can be stopped.
   - Pooling of knowledge and resources utilized.
2. Actual facts — correct information — self esteem.
3. Problem solving — self esteem.
   - Gaining skills.
   - Learn how to make decisions.
   - Validation.
   - They make their own decisions — we do not. We are not down on men and do not take sides on issues.
   - Just present the information.
4. Follow up — no ongoing support group — our rationale. i.e., individual or different type group such as regular support group or psychodynamic group.

Community Reactions to the Deinstitutionalization of Psychiatric Patients

Dr. Barry Hall, Ph.D.
Dr. Don Collins, Ph.D.
and
Mobashar Butt, M.S.W.
Claresholm Care Centre
Claresholm, Alberta
Ph: 625-3301

Claresholm Care Centre has been located in this small community of about 3,600 people for more than half a century. In the past few years emphasis has been placed on discharge of residents to the local community with necessary support from Adult Day Program. As a result, some concerns were expressed by different groups in the community about deinstitutionalization of mental patients. It was thus decided to do research on the subject. For the reasons of making this study unbiased and to encourage community participation, arrangements were made to involve Barry Hall, Ph.D. and Don Collins, Ph.D., Faculty of Social Welfare, University of Calgary, Lethbridge Division.

This study was designed to assist the Claresholm Care Centre in determining community reactions to the deinstitutionalization of mentally ill patients in Claresholm, Alberta. A total number of 1472 survey questionnaires were sent to all households in the Claresholm area through the local Post Office. Included with the questionnaires was a letter and post-paid return envelope from researchers from the University of Calgary. Five hundred and twenty three (523) people responded to this attitudinal study.

In general, the results of this study indicate that residents of Claresholm are quite knowledgeable about psychiatric illness, as well as understanding of psychiatric patients. The Claresholm community is supportive of the location and delivery of psychiatric services in their community. The community is tolerant and supports the deinstitutionalization of psychiatric patients.

Four demographic variables were examined: age, employment, education, and income. It was found that respondents under the age of 55 tended to have a more understanding attitude toward the mentally ill in Claresholm than did those respondents who were 55 years of age or over. The respondents in Claresholm who were employed full time seemed to have a more receptive attitude toward the mentally ill than those people who were retired. The research has shown that the strongest predictor of a positive attitude towards mentally ill in the community is education, followed by age, employment, and then income. Respondents whose educational status is college or more tend to have a more accepting attitude towards the mentally ill than people who have an education of high school or less. Respondents earning less than $20,000.00 tend to have a more accepting attitude towards the mentally ill than people earning more than $40,000.00 per year.

The study has also demonstrated that the community does not view the Claresholm Care Centre as having the sole responsibility for providing treatment to the mentally ill population. The community views itself as having some social responsibility in the treatment of mentally ill people.

The Claresholm Care Centre needs to take an active role in further educating the Claresholm population about the mentally ill.

Announcements

The Suicide Information and Education Centre

The Suicide Information and Education Centre (SIEC) is a computer-assisted resource library containing written and audiovisual materials specific to the topic of suicidal behaviours. This world class resource centre, located in Calgary, is another example of Alberta's continued commitment to suicide prevention.

The Suicide Information and Education Centre (SIEC) was established in 1982 so that health care professionals, researchers and members of the public could have convenient access to a complete resource centre on the topic of suicide and suicidal behaviours. SIEC is a non-profit organization and operates under the auspices of the Canadian Mental Health Association. Funding for the Centre is mainly provided by the Government of Alberta, Alberta Health, through an annual grant from the Suicide Prevention Provincial Advisory Committee (SPPAC).

The aim of SIEC is to collect all of the literature regarding suicidal behaviours which has been published in the English language since 1955 and to make this collection available to all interested persons. The Centre maintains a computer database which currently contains more than 11,500 citations. The database is continually updated with citations to newly published journal articles, books, unpublished manuscripts, conference proceedings and audiovisual materials.

The Centre provides literature searches and photocopies of articles from the collection in response to specific requests.

Although the SIEC central office is located in Calgary, regional access to the database has been made available through the establishment of six Host Agencies in the province. The Canadian Mental Health Association hosts these terminals in: Medicine Hat, Lethbridge, and Grande Prairie (co-host). AID Services of Edmonton, and the Fort McMurray Suicide Prevention Program are Host Agencies in those locations. In addition to Host Agencies, the Suicide Information and Education Centre can be accessed directly over the phone lines by an agency or individual with a compatible computer terminal.

As an information clearinghouse, SIEC also publishes a monthly *SIEC Newspaper Clipping Service* ($25.00/year) and a quarterly newsletter *SIEC Current Awareness Bulletin* ($20.00/year) that contains program and conference news, reviews and an updated list of newly acquired items available from SIEC.

Requests for information, including Host Agency addresses, can be directed to: Information Officer, Suicide Information and Education Centre, 201, 1615 - 10th Avenue S.W., Calgary, Alberta, T3C 0J7, Telephone: (403) 245-3900.

Therapy Group for Adult Survivors of Child Sexual Abuse, Held in a Rural Mental Health Setting

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Nine female clients of Alberta Mental Health Division, Brooks, participated in a total of 20 group therapy sessions, held during the summer and fall of 1987. The sessions were grouped into two phases, with five clients participating in the first phase, and an additional four clients in the second phase. Prior to beginning the group, all but two of the clients had been receiving individual therapy from the therapist who ran the group. Due to the lack of another female therapist on staff, the group was co-facilitated by a client with substantial experience in a self-help group.

The women ranged in age from 21 to 41 years of age, with most being in their early 30s. Six were married and all but one were parents. Seven had received mental health therapy in the past, but none had been previously treated for their childhood sexual abuse. Two-thirds had never before disclosed their past sexual abuse. There was wide variability as to clients' relationship to their offenders.

The sessions were held weekly, in the evenings, and attendance was 90% in the first phase and 70% in the second. The sessions were from 2 to 2-1/2 hours in length. Among the therapy techniques evaluated as being most effective (by both clients and therapist) were: personal goal statements, journaling, unsent letters to offenders, group discussions, anger expression exercise, and the use of "emotional garbage bags." Anticipated problems with confidentiality in such a small community did not materialize.

An evaluation of the therapist's first experience in facilitation of such a group has led to the following recommendations:

1. That professional education be enhanced so that most therapists will be able to identify and treat more adult survivors earlier in the course of therapy;
2. That two trained co-therapists be available, in order to firmly establish and maintain boundaries with respect to structure and process of group sessions;
3. That there not be any additions to group membership once the sessions get underway;
4. That maximum group size be eight, and that the duration be of at least 16 sessions. If there are more than five or six members, then consideration should be given to extending the length of each session from 2 to 2-1/2 hours;
5. That although most members expressed a need for continued individual sessions (in addition to group meetings), the question of therapist burn-out also needs to be addressed. In a small community, it is likely that group and individual therapists would come from the same agency and would likely have to fulfill both roles. If caseloads are high, it would probably be best, while group therapy is underway, to offer individual sessions only on an emergency basis.

Mental Health Consultation — An Essential Skill in an Era of Fiscal Restraint

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This paper outlines an increasing need for mental health consultation skills in view of increasing interaction between mental health therapists and other professionals, laymen, families and patients. Demand for services continues to outstrip supply as a result of changing emphasis — from crisis intervention to prevention; institutional care to community care and government funding to privatization. With the changes has come an increase in the use of multidisciplinary health services and non-professional support systems. For many therapists, traditional training provides poor preparation for these different settings because it is based on individual and group psychopathology in institutions with minimal consultation, liaison and multidisciplinary experience. Without specific training in mental health consultation, inexperienced therapists are often threatened by these different settings and may become defensive and authoritarian in response. Other professionals see this as arrogance and condescension and effective input may be severely impaired. This paper suggests that skills in mental health consultation allow more comfort and confidence to encourage other professionals to maintain their autonomy and increase their skills to the benefit of their clients. Experience with a seminar and supervision program is described. There are some qualitative indications that training in mental health consultation enriches traditional training promoting cooperation and collaboration with other professionals. This increases effectiveness and makes for a more satisfying practice with strong mutual support systems.

"From the Inside Out": Drawing a Life History

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Drawing a life history is a technique in which the focus is on the child's unique development and his personal view of his personal history: his story told "from the inside out." It is a creative process involving both child and therapist where the child draws his (or her) life as he remembers it or as he believes or imagines it to have been. The drawings can be very helpful to the therapist, the parents and the child himself, and it is a method that seems to fit especially well with children with chaotic backgrounds and multiple moves.

The history starts with the birth-day and moves through his life looking at significant events. The chronological ordering of the jumble of memories can assist in making sense of emotional reactions and identify sources of anger and grief. For the child, the act of drawing may itself be a healing process. He may be able to recognize some good times and some personal strengths which can give him hope for the future.

Interviews with Children Using Art Therapy Techniques

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Interviewing children using a variety of art therapy techniques can be a comfortable way of having a discussion with children about their feelings and their views of family interactions. Art is a useful tool for several reasons:

1. Unless severely limited, everyone can draw.
2. Drawing is fun.
3. Using art with children provides them with a comfortable way of expressing themselves in a way they are familiar with and in a way they understand.
4. Art provides a way to express feelings with pictures, even if you cannot talk about your feelings. Art is a visual language or visual communication.
5. Art provides a permanent record and is something concrete to respond to and to review later without distortions of memory.
6. An art assessment, if done carefully, can point out where resistance is, the basic structures of the family, where the power lies in the family, the family rules, the communication styles, etc.

During this presentation, a variety of techniques were demonstrated through color slides of the drawings of eight different children, ages ranging four to fourteen. Brief family histories were presented for each child in an attempt to demonstrate that the children's art and their interpretation of their art enriched the information already gathered about the family. The drawings are reviewed with the parents to help provide the family with information about the child's thoughts and hopefully to point out the influences family members have on each other's behavior.

Recent Additions to the Mental Health (Head Office) Research Library

Recent Trends In Outpatient Services to Priority Client Groups
(Revised Sept. 30, 1988)
H. Borowski
Mental Health Division (Head Office)
427-2816

Preliminary Evaluation of the Slave Lake, Alberta,
Crisis-Initiated Brief Interventions Project
P. Haines, A. McLaughlin, E. Adams
Mental Health Division (Northwest Region)

Retrospective — Mental Health Division — 1986 to 1987
Prepared by: Mental Health Division and Management Support Services
December 1988
427-2816

Approved Home Evaluation — Central Region — 1986
V. Ward, M. Wessel
Mental Health Division (Central Region)
340-5047 (151-5047)

ARIES — AMHMPS Research, Information and Evaluation Subfile
Prepared by the Mental Health Division (Head Office) February 1989
427-2816

RESEARCH & INFORMATION
MENTAL HEALTH NEWSLETTER

is published quarterly by the Mental Health Research Unit (Head Office) and distributed to departmental employees interested in research issues and related information.
Acting Editor:
George Stebelsky

Recent Publications by Mental Health Division Staff

Newman, S.C. & Dyck, R.J. Age-period-cohort analysis of suicide rates. *Psychological Medicine*, 1988, *18*, 677-681.

Thompson, A.H. Children in care: High risk for mental disorder. *Canada's Mental Health*, 1988, *36*(4), 24.

Eustace, J. and Knowlton, E. Social adjustment of chronic psychiatric patients in the community. *Alberta Psychology*, 1989, Vol. 18, No. 2, 11-14.

Smith, S.A. and Marshall, W.L. Alternative programs in a psycho-geriatric hospital. *Dimensions*, March 1989, 17-19, 33.

If you require additional copies of the newsletter, or know of any individual or group that would like to receive future issues, please call at 427-2816 or write to the Director of Mental Health Research and Evaluation, 4th Floor, Seventh Street Plaza, 10030 - 107 Street, Edmonton, Alberta, T5J 3E4.

Recent Projects Approved by the Alberta Mental Health Services Research and Ethics Review

Designation Study Proposal
J. Arboleda Flores
Calgary Region

Protection of the Elderly — A Study of Elder Abuse
S.A. Smith
Rosehaven Care Centre

Alberta HEALTH

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RESEARCH & INFORMATION

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Follow up study of a residential treatment program for severely psychiatrically disturbed adolescents

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(in press, Canadian Journal of Psychiatry)

The present study is the continuation of a previous study reported at the Canadian Academy of Child Psychiatry in 1987 of a six month follow-up of a residential treatment program for severely psychiatrically disturbed adolescents. This study is a 2 to 3 year follow-up of the first 40 patients treated and discharged from the facility. In the present study, our follow-up criteria were concerned with the psychosocial functioning of our discharged patients at follow-up.

C.A.S.E. House is a ten bed free-standing residential semi-secure treatment program for severely dysfunctional adolescents with serious psychiatric problems. The program was specifically set up to address the problems of the multiproblem adolescent with poor community and family supports, with a history of unsuccessful, often repeated treatments. These children often have histories of extensive Child Welfare involvement, multiple failed placements and are considered as continuing high risk cases. C.A.S.E. House is part of a comprehensive community based adolescent program incorporating a model of continuity of care. The total program provides a fully integrated resource with hospital backup, day and evening programs and ongoing follow-up.

The program recognizes the need for a positive mental health focus with accent on developing social coping skills rather than just symptom amelioration. The residential program is the entry point into a comprehensive community program, stressing continuity of care. Patients (students) graduate through the various program components and are never formally discharged and follow-up is made available as required until young adulthood.

The philosophy of C.A.S.E. House recognizes the primacy of the family as a protective and necessary support matrix for the healthy development of children and adolescents. In this respect, the residential unit is conceptualized as a therapeutic family allowing the opportunity for reworking of early developmental trauma related to the family, and enabling the adolescent from a severely dysfunctional family to internalize a symbolic stable family construct so important for the development of healthy ego skills in adulthood.

Although the family systems philosophy is the core of the program, actual treatment is multimodel and is based on a modified therapeutic community format. There is a daily insight directed community therapy group and various other structured and unstructured small therapy group formats employing a mainly psychodynamic/systems oriented framework. Treatment also encompasses family therapy, educational remediation, parent education and support, and chemotherapy as required.

The staff is multidisciplinary and includes the full range of mental health specialties. Psychotherapy is limited to group and family therapy only, no individual counselling is offered. A teacher is provided for educational remediation.

The program is open ended, the average length of stay is about four to six months following which the successful residents may graduate to one of the community programs or may be referred to alternative appropriate community agencies for support. Treatment goals are specified in terms of four areas: self, school, family, and community. Treatment progress is ascertained by means of staff and resident feedback on a regular basis.

Introduction

The Research and Information Newsletter is published by the Mental Health Research Unit in order to make it possible for Alberta Health personnel and organizations to keep abreast of current research and information related to mental health and other departmental programs.

The newsletter will present abstracts or summaries of selected relevant articles or papers produced by the Mental Health Division staff. These will include new projects, published or unpublished papers, conference presentations, as well as research news.

If you feel you have an article which you think should be included in the newsletter, please submit a summary of your work (maximum 1000 words).

Follow up, continued from page 1
using a psychosocially based rating system.

The present study sample consisted of 40 teenagers admitted to the program between 1984 and 1987. Mean age was 14.6 years. The sample was analyzed at three different periods; admission, discharge and 2 to 3 years follow-up. Measures used included the Global Assessment Scale, the Level of Functioning Scale and our own scale, the Adolescent Functioning Scale. Independent raters were used to minimize any reporting bias. Altogether 34 of the original sample were traced at the follow-up point.

Results

The results of the study showed significant positive changes on all three rating scales which were continued over time. For example, from admission to follow-up on the Global Assessment Scale, scores went from 28.2 to 68.8 ($z = 4.77$, $P < .001$). On the Level of Functioning Scale, scores went from 2.5 to 7.1 ($z = 5.01$, $P < .001$). On the Adolescent Functioning Scale, similar significant improvements were seen on all subscales.

Discussion

In general, our findings suggest that the treatment model is successful in community rehabilitation of the majority of the study sample. The most encouraging finding of the study was that it was possible to induce lasting positive changes in this usually unresponsive group with a poor response to traditional treatments. This is deduced from the continual improvement of all the adolescents located at the follow-up point.

It is, of course, possible that effects other than the treatment program, including natural maturation and spontaneous recovery, were responsible for the improvements noted. If this is indeed so, then we need to review our ideas about long term prognosis of adolescents with severe psychiatric dysfunction.

Criticisms can also be levelled at our inability to include a control group. However ethical considerations, our service mandate, and the lack of alternative programming for such children in this region made the provision of a control group impossible.

Our experience in treating this population reinforced a number of the assertions about successful child and adolescent treatment. This included the importance of addressing psychosocial coping skills in treatment; the relevance of a multimodel treatment model; the importance of continuity of care and the importance of the family in child and adolescent treatment even when a biological family was not available.

The overall results suggest that the program model described is successful in addressing many of the problems associated with the management of the severely dysfunctional adolescent with psychiatric problems. The program confirmed the importance of the family in child and adolescent development. In particular the program seemed successful in addressing the needs of the psychiatrically disturbed adolescent from the severely dysfunctional family, especially those who often find their way into child welfare or forensic settings or join the ranks of the young adult chronic population.

Psychiatric disorders in prisoners

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This project was supported by the Provincial Mental Health Advisory Council. Assistance was provided by the Alberta Solicitor General staff.

This study was part of the overall investigation of the prevalence of psychiatric disorders in adult residents of Edmonton.

The purpose was to determine the prevalence of psychiatric disorders in prisoners and to compare this with the prevalence in the population from which the prisoners were drawn.

The previous study of prevalence in Edmontonians was based on 3,258 interviews of randomly selected adult household residents of the city. This represented a 72% response rate. All subjects were interviewed by trained lay interviewers using the Diagnostic Interview Schedule, a standardized psychiatric diagnostic interview, which yields DSM-III diagnoses, using the Washington University computer program. Diagnoses have been used hierarchy-free, that is, without exclusion criteria.

For the study of prisoners, we required a random sample of those serving prison terms and who originated from Edmonton. The two institutions which serve these prisoners are the Fort Saskatchewan and Belmont correctional centres. While these two centres only admit offenders sentenced to up to two years, those given longer sentences may serve them anywhere in Canada in the Federal system and are then not readily accessible. Interviewing was done in two waves of 10 days each in December 1986 and January 1987. Samples were drawn by systematically sampling the inmate roster on these occasions and eliminating duplications. Substitutions were made when an inmate was not available by taking the next name on the list. A total of 222 inmates were interviewed (194 men and 28 women) for an 80% response rate. Since all except 14 of the men were under 45 years, we confined our analysis to those under age 45. The interview instruments, methods of analysis and interviewers were the same as those used in the community survey.

For purposes of comparison with the population, expected numbers of cases for the prison population were generated from the population study (using the age and composition of the prisoners). This was then compared to the actual number of cases found among the prisoners. This we have called the standardized prevalence ratio which, if the inmates and the general population have the same rate, will equal one. A figure greater than 1 indicates an excess of cases in the inmates.

Some results

Even though few prisoners were 45 or older, they were at the younger end of the

18-45 range. Native Indians were 12% of the prison group but only 2% of the population. Inmates were also less likely to have been married, were poorly educated, and more likely to have been unemployed. The most common offense was impaired driving followed by breaking and entering. Over half had been previously convicted in juvenile court and the majority were repeat adult offenders. Three quarters of all prisoners had a history of a psychiatric disorder (about four times the rate in the general population). The most common lifetime disorders for male prisoners were substance use and antisocial personality and, for females, substance use, affective disorder and antisocial personality.

Prisoners were more likely to have had recent symptoms of their disorder, and current distress (shown by the General Health Questionnaire) was much more frequent than in the household population.

Male prisoners were 11 times (and females 4 times) more likely to have made a suicide attempt than those in the population.

Comment

We found no study in the literature where a direct comparison of prisoner and population prevalence was possible. This study clearly demonstrates much higher prevalences in prisoners than in the general population. The demographic profile of prisoners shows them to be a disadvantaged group in several ways. They are young, unmarried, male, unemployed with poor education, previous convictions (both juvenile and adult), and with a higher than expected proportion of Native Indians. They are likely to be involved with alcohol and/or drugs and have antisocial personalities, in addition to a variety of other psychiatric disorders and a propensity of suicide attempts.

While careful assessment may identify those with disorders, and those who are high suicide risks, suggesting effective treatment programs for this population with multiple diagnoses and established behavior patterns presents many difficulties.

Mental Health Services follow-up to the Edmonton tornado disaster: A descriptive analysis

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The tornado which struck Edmonton on July 31, 1987, and the ensuing destruction to property and loss of life, left many survivors in need of services from a variety of agencies, including Mental Health Services. In order to be better prepared for similar future crises, it is necessary not only to plan and develop disaster services within Mental Health Services, but also to establish a clinical profile of the typical disaster survivor. Future disasters such as this one could be dealt with more efficiently and effectively if services are prepared in advance and if the general characteristics of victims accessing community and human service agencies are known and understood.

Using a sample size of 83 survivors of the Edmonton tornado disaster who were referred for mental health treatment, the present study sought to ascertain the significance of such factors as the determinants of disaster recovery, the effects of age on recovery prognosis, the effects of gender on the disaster process, latency of response, social support levels, and the effects of property loss and death of significant others. Seven areas of particular interest were explored by means of 3, 4, and 7 point scales: referral information; sociodemographics; social network support; extent of loss; client information; diagnosis; and treatment.

Previous research into the immediate and long-term consequences to both individuals and communities having experienced the stress of disaster has revealed interesting, yet inconclusive, results. With respect to age, some studies have pinpointed the young and the elderly as most likely victims of psychological impairment following a disaster. However, age interacts with other factors such as availability of social and family support, extent of life experience, gender, and health to determine an individual's ability to cope with the experience of disaster. Men and women have demonstrated different reactions to the disaster process, with females experiencing elevated onset levels for generalized anxiety disorder, major depression, and post-traumatic stress disorder, while males evidenced elevated levels of generalized anxiety disorder only. Variables such as latency of response to the disaster, occupation, marital status, social support availability, past and concurrent experience with disasters, and degree of life and property loss have also been illuminated as salient factors in past research.

The present study yielded significant findings in each of the seven categories. The majority of survivors were referred by Public Health nurses or were self-referred. Most referrals were made in December, five months after the tornado struck, and the most frequent response time, the time between the date of referral to the date of assessment, was two to six days. Of the survivors accessing services, 36% were between ages 20 and 34, making this age group the most frequently represented. A significantly higher percentage of females than males sought services, half of the 83 sample survivors were married, and greater than 50% held full or part-time jobs.

Information regarding social network support revealed that of the 57% of survivors who were married or living common-law, the majority had spouses rated by the reviewer as "in conflict" or "unsupportive." "Poor," "weak," or "non-existent" family support described almost 50% of the sample, and social support was rated "poor" and "weak" in 48% of cases. In the area of extent of loss, the majority of the sample did not suffer personal injury or death of significant others, although 31% experienced extensive property loss. However, half of the survivors reported suffering stressful life events prior to the disaster and 83% reported experiencing concurrent stressful situations not related to the tornado. Nearly one-quarter of the sample had received previous mental health treatment. Post-traumatic stress disorder was the diagnosis in 57% of the cases, 27% were

diagnosed as having adjustment disorder, and 61% were given the diagnosis of having been exposed to a catastrophic psychosocial stressor. A majority of survivors received five or more treatment sessions, usually in the form of individual support therapy. A total of 45% of the files were eventually closed as a result of client dropout.

These findings facilitated the construction of a typical tornado survivor profile. The characteristic survivor accessing services was female, somewhere between the ages of 20 and 34, working in a low white collar occupation such as clerical or sales positions. The typical survivor lacked family and community support, had experienced or was experiencing some degree of psychological and psychiatric disturbance at the time of the disaster, and was undergoing non-disaster related stressors. Moreover, the survivor suffered from some sort of post-traumatic stress syndrome or adjustment disorder, and was likely experiencing difficulties in personal relationships.

This model having been formulated, several alternatives have been postulated. Outreach counselling performed by experienced teams could be carried out on-site, with referrals to other treatment centres being made where appropriate. Treatment must be priorized to ensure that the most acute cases are attended to first. Individual as well as group therapy have proven to be successful treatment options. Debriefing is vital to foster family and social support which could provide protection to survivors against future psychiatric disturbances. Identification of high-risk groups, such as those with personality disorders, could serve as a useful preventive measure. The information collected should prove valuable in identifying highly vulnerable individuals and groups and assessing how their needs might best be met in the event of a future disaster.

Recent projects approved by the Alberta Mental Health Services research and ethics review

Alberta Heart Health Survey
Dr. M. Joffres
Public Health Services

Announcements

- The 60th anniversary of community mental health clinics in Alberta is being celebrated this year. Special activities have been planned throughout the province, and commemorative posters and pins have been commissioned. Please contact Ms. Judy Barlow, Director, Mental Health Promotion (427-2816) for further information.
- Dr. K.F. McKenna, Assistant Professor, Department of Psychiatry, University of Alberta, will be conducting a research presentation regarding the causes and treatment of panic disorders. The seminar will be held in room 601, south tower, Seventh Street Plaza, Edmonton, at 1:30 pm, November 24, 1989. For further information, please contact Peter Campbell, Editor of the Research and Information Newsletter (427-2816).
- The Departments of Social Work and Psychology at the Alberta Children's Hospital will be co-sponsoring a conference on March 22 and 23, 1990, "Clinical Interventions with Stepfamilies" by John and Emily Vischer. The fee for Non-Alberta Children's Hospital staff will be $100. For more information, please contact Diane Everatt (229-7039) or Gisele Pilon (229-7964) at the Alberta Children's Hospital.

Recent additions to the Mental Health (Head Office) Research Library

Elder Abuse and Neglect Survey
S.A. Smith
Mental Health Division, Rosehaven Care Centre, Ph: 679-1411
March, 1989

Research Priorities for Children's Mental Health
P. Campbell, Mental Health Division, Head Office, Ph: 427-2816
December, 1988

Provision of Services to Children with Behavioral or Emotional Problems — An Update of Provincial Services
P. Campbell
Mental Health Division, Head Office
Ph: 427-2816
December, 1988

Mental Health Follow-up to the Edmonton Tornado Disaster: A Descriptive Analysis
J. Eustace, A. Mazo, S. Hein, Mental Health Division, Edmonton Region
Ph: 427-3435

Recent publications by Mental Health division staff

Bland, R.C., Psychiatric Epidemiology, *Canadian Journal of Psychiatry*, October 1988, Vol. 33.

Blackman M., Eustace J., Chowdury T., Follow-up Study of a Residential Treatment Program for Severely Psychiatrically Disturbed Adolescents, *Canadian Journal of Psychiatry*, 1989 (in press).

Blackman M., Eustace J., Chow H., An Extended Family Model for the Treatment of the High Risk Adolescent with Psychiatric Problems, in Roberts, R. *Adolescents in Secure Settings*, Thistletown Foundation, Etibicoke, 1989, pp. 294-308.

Thompson A.H., Bland R.C., Orn H.T., Relationship and Chronology of Depression, Agoraphobia, and Panic Disorder in the General Population, *The Journal of Nervous and Mental Disease*, Vol. 177, No. 8, pp. 456-463.

RESEARCH & INFORMATION
MENTAL HEALTH NEWSLETTER

is published quarterly by the Mental Health Research Unit (Head Office) and distributed to departmental employees interested in research issues and related information.
Editor: Peter Campbell

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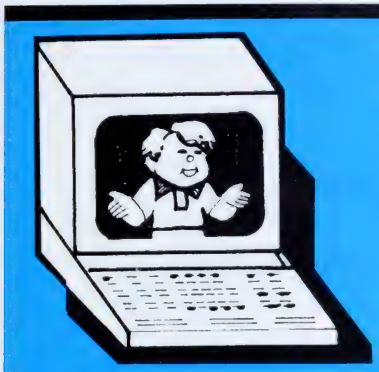
Alberta HEALTH

Volume 5 Number 1 Summer/Fall 1990



RESEARCH & INFORMATION
MENTAL HEALTH NEWSLETTER

Urban Attitudes on Treatment and Intervention for the Mentally Ill

A.H. Thompson and Peter Campbell: Mental Health Division; Ron Lajeunesse, Canadian Mental Health Association.

Interest in attitudes toward the mentally ill has been longstanding. The issue is perhaps of increased importance now because of rekindled emphasis on deinstitutionalization and the advent of the "health promotion" model of intervention. These approaches will, in general, result in a greater number of individuals treated in their home communities, and may well require a greater level of community involvement.

Considering the view that some of the failures of the deinstitutionalization process have been due to a lack of public support, it is crucial that the development and implementation of such social policy be preceded by an examination of the readiness of the general public for any major changes in service delivery.

This study was designed primarily to collect information for planning future mental health services and to assist in the preparation of media campaigns; that is, to tap current attitudes in a large city, and to search for attitudinal differences as a function of factors already identified in the literature.

Procedure

Two thousand questionnaires were mailed out to individuals listed on the 1986 voters list for the city of Edmonton. Four hundred and ninety questionnaires were returned unopened by Canada Post due to the fact that the person was not at the address (the voters list was slightly more than two years out of date). Of the 1510 remaining questionnaires, 452 (29.9%) were completed and returned.

Results

Respondents showed a general understanding of mental illness when asked to rate a variety of symptoms. Most frequent selections were depression, mood swings and hallucinations.

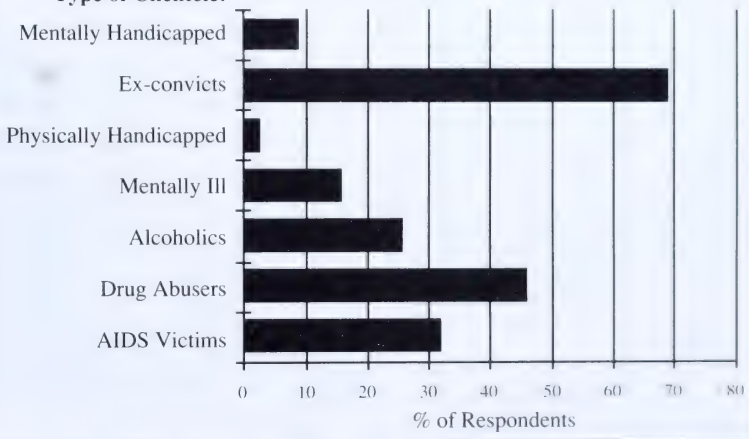
In terms of support, only seven percent of the respondents stated that they would object to a formerly mentally ill person at their workplace, but 30% would object to a mentally ill relative living in their own home.

The extent of opposition to a variety of neighborhood group homes is shown in Figure 1. Overall, very little objection was expressed toward the presence of homes for the physically disabled or the mentally retarded. A home for the mentally ill was ranked third, placing well ahead of the remaining four. In terms of a group home for the mentally ill, a minority of 16% showed a negative view, of which, only five percent were "extremely negative" (ie. would take action to prevent the creation of a home for the mentally ill).

On the positive side, 67% were moderately supportive, including 21% who would take some action to support a home for the mentally ill in their neighborhood. These data are in line with the previous findings in the literature that only a minor-

continued on page 2

Figure 1: Opposition to a Variety of Community Residences



Urban Attitudes, continued from page 1

ity of the members of the general public display a negative attitude toward the mentally ill.

Forty-two percent of the respondents reported that they felt that the mentally ill were more dangerous (in terms of assault, rape, murder) than the non-mentally ill population. Forty percent felt there was no difference, and 18% rated the mentally ill as less dangerous than those not mentally ill. Clearly, dangerousness is a significant issue, however, 77% were optimistic that mental health treatment would reduce dangerousness.

The question "if 100 people suffer from a mental illness, how many of them will recover...?", produced a mean estimate of 52% (SD=28.0), with the range running the gamut from none to one hundred percent.

Subjects were presented with a list of potential causes of mental illness, asked to endorse as many as they wished, and then to rank their top three choices. The outcome (Figure 2) was surprising, contradicting other findings that social/environmental factors are generally perceived to be predominant. In fact, "physical" factors ("problems in brain chemistry" and "genetic inheritance") both ranked in the top three in terms of endorsation rate, and were first and second (totalling 71% of responses) when only the "most important cause" was considered.

"Severe psychological shock" (loss of a loved one/disasters) was highly endorsed overall, but took on much less importance as a primary cause. It is interesting that the items "poor upbringing by parents" and "breakdown in society" are perceived to have a relatively minor role.

Sixty-one percent of individuals had either a friend or relative with mental illness, 11% had worked in a mental health setting, and 23% had seen a professional for an "emotional" problem. There was some overlap in these categories; those having had experience in one or more of the three areas totalled 66%.

When asked to respond to a list of potential initiatives for the purpose of "dealing" with mental illness, respondents strongly endorsed the need for more research and public education, as well as programs providing community support for the mentally ill (Figure 3). Respondents showed much less support for increased use of psychiatric hospitals and medications for the treatment of mental illness. This last point raises an interesting paradox, namely, that the public views the causes of mental illness to be physical (genetic/biochemical), but supports programs offering nonmedical treatments.

Figure 2: Perception of Important Causes of Mental Illness

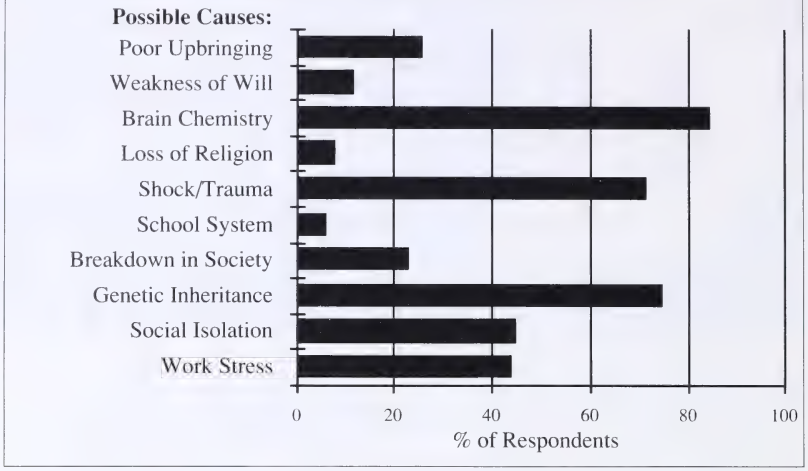
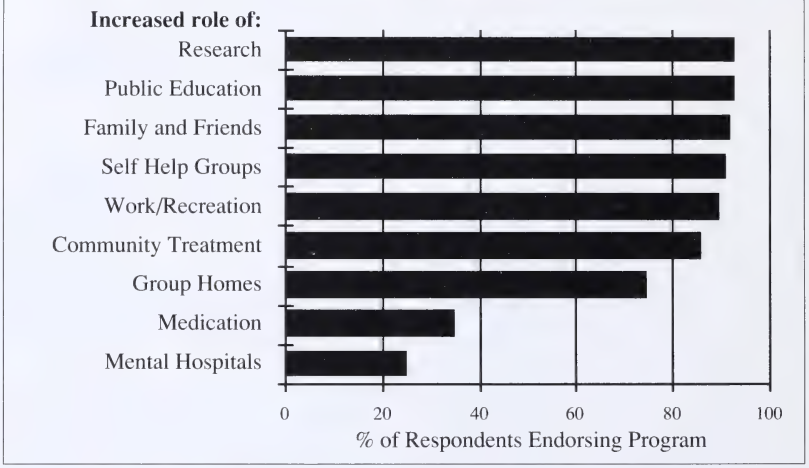


Figure 3: Support for Potential Initiatives Dealing with Mental Illness



Conclusion

The results of the survey indicated that members of the general public are quite knowledgeable about the causes and symptoms of mental illness, and are supportive of the mentally ill. It should be noted that the results of this survey do not necessarily reflect the reality surrounding mental illness, but rather what the public believes and accepts in terms of the use of health resources for the treatment of the mentally ill.

The public was overwhelmingly supportive of research, public education, input from family and friends, and the use of self help groups and work/recreation programs for the mentally ill. To a lesser extent, the public was supportive of community treatment and the use of group homes for the mentally ill.

Given the current trend of deinstitutionalizing the mentally ill, it is important to know that the public is supportive of community programs for the mentally ill, and that further support may be gained through increased public education and health promotion.

Attempted Suicide and Psychiatric Disorders in a Jail Sample

Ronald J. Dyck: Mental Health Division; Roger C. Bland, Stephen Newman and Helene Orn: Department of Psychiatry, University of Alberta Hospital.

Although the epidemiology of suicide has received increasing attention over the past two decades (Syer-Solorsh, 1986; Boldt, 1976; Diekstra, 1987), suicidal behavior in those who are incarcerated has received the benefit of very limited enquiry. This has occurred even though the evidence indicates that suicidal behaviors are common in prisons, jails and detention centres (Ramsay, Tanney and Searle, 1987; Burtch and Erickson, 1979; Stone, 1984).

In Canada, Ramsey, et al. (1987) reported that the suicide rate in the federal prisons is more than eight times the rate in the general population. Others have reported rates of suicide in jails and prisons that are up to 47 times that found in the general population (Burtch and Erickson, 1979).

Although there are some exceptions, suicide has been found to be the leading cause of death in most penal institutions (Burtch and Erickson, 1979). In addition to the high rate of completed suicide is the high rate of non-fatal, self-inflicted injuries among inmates. Ramsey, et al. (1987) reported that the rate of such behavior is more than twice the estimated rate found in the general population.

While it may be logical to conclude that suicide among inmates is caused by specific factors in jails (Stone, 1984), a stronger explanation may be that the jail populations are made up of more vulnerable individuals. Previous research has indicated that suicidal inmates tend to be male, younger than the average inmate, divorced, have a history of psychiatric problems and a history of past suicide attempts (Danto, 1972; Esparza, 1972; Beigel and Russell, 1972; Hankoff, 1980).

It should be pointed out, however, that these studies suffer from a series of methodological problems (e.g., small samples, sizes, unreliable data, no comparison or control group) which make conclusions only tentative. Therefore, it is important to examine further the characteristics of inmates that may contribute to their vulnerability to suicide.

The purpose of the present study was to explore the relationship between suicidal behavior (suicide attempts) and psychiatric disorders, as well as other social variables in an inmate population. For the purpose of highlighting similarities and differences, comparisons were made to the general population on the basis of data obtained in a previously completed survey of a large community sample using the same interview schedule, diagnostic methods, and interviewers (Bland et al, 1988) as in the present study.

Two hundred and twenty-two (222) inmates over the age of 18 years were randomly selected from two correctional centers and interviewed. The main survey instrument was the Diagnostic Interview Schedule (DIS), a highly structured questionnaire. Diagnoses were made hierarchy-free according to the same DSM-III criteria employed in the earlier study. Respondents were also administered the 30-item General Health Questionnaire (GHQ), a brief screening test designed to detect recent symptoms of anxiety and depression.

Of the inmates interviewed (194 men and 28 women), only 14 males and no females were 45 years of age or older. Thus, the data analysis in this paper has been restricted to males in the 18-44 age range; 180 inmates and 1,006 community residents.

Analysis of the data revealed a lifetime prevalence rate of 22.8% for attempted suicide, a rate 7 times more frequent than in the general population. Inmates were twice as likely to have a lifetime psychiatric disorder compared to the general population, and all individual disorders investigated were found to be more common in the jail population. The number of individual disorders per inmate was also higher than for the general population.

When inmate attempters were compared to inmate non-attempters, several disorders were found to differentiate these groups. Specifically, attempters had significantly higher lifetime rates of Substance Use Disorders, Antisocial Personality, Affective Disorders, and Anxiety/Somatoform disorders, especially Panic and Obsessive-Compulsive. Moreover, feelings of hopelessness, sadness, depression, thoughts of wanting to die, and committing suicide were significantly more prevalent among attempters.

Surprisingly, violence (made up of such items as hitting or throwing things at one's spouse or partner, child abuse, fights) was not found to differentiate attempters from non-attempters. No differences were found on GHQ scores indicating that attempters and non-attempters alike were exhibiting symptomatology indicative of high levels of distress.

The findings of this study are of particular relevance to those with special interest in suicidal behavior among prisoners. First, those with responsibility for developing policies and procedures need to give detailed consideration to the area of psychiatric assessment for newly incarcerated individuals. Since many inmates report a history of suicidal behavior, and even more a psychiatric history, it is critical that policies and procedures be developed which will ensure adequate psychiatric assessment at the point of entering the system and treatment while incarcerated.

Second, mental health care professionals need to ensure that an assessment of the risk for suicide is an integral part of inmate psychiatric assessment. The question of how to manage and treat the identified at-risk group is one that needs much more study.

Finally, these data are important to those in government responsible for guiding general health, and in particular, mental health policy. Since so many of the inmates have a current psychiatric disorder, it is critical that a strategy for mental health promotion and education be established.

Family Empowerment — Effectively Engaging Families in Care Sharing: The Ambiguity In Division of Tasks

Stefan Achkewich:
Rosehaven Care Centre;
Summarized by Linette McNamara:
Mental Health Division.

In response to growing interest in the concept of 'care-sharing' — formally and actively involving the family as part of the care giving team — Stefan Achkewich has conducted a study of the Rosehaven Care Centre, a 200 bed psychogeriatric hospital for the chronically mentally ill. A growing emphasis on deinstitutionalization, community empowerment and prevention in recent years has prompted Rosehaven to support the idea of the family as part of the health care team. Family support groups, adult day hospitals, short term assessment, respite care and pre-discharge programs have been instituted with the intent of linking the institution, community, family and patient.

However, as the institution begins to shift from the role of sole care giver to that of care manager, ambiguity has arisen about which tasks are to be performed by whom. There has been resistance on the part of staff to turning over care tasks to families, and some families have in turn been reluctant to get involved. The study was therefore designed to 1) find out what tasks families and staff see as family, joint or institutional responsibility and 2) find out where families and staff agree and disagree.

Fifty Rosehaven staff members and 50 relatives of patients filled out a 100 task inventory in which they indicated whether primary responsibility for each care task rested with 1) the facility, 2) jointly with the facility and family or 3) with the family. The 100 tasks were divided into 13 groups: personal care (including religious needs), housekeeping tasks, diet related tasks, activity tasks, patient care tasks, counselling, medical tasks, security tasks, family relations, administration, transportation, extras, and supplies.

Results

The responses to the inventory assigned responsibility for the 13 care task groups as follows:

Care Tasks	Primary Responsibility (As rated by both groups)		
	Family	**Joint**	**Institution**
Personal Care		X	
Housekeeping			X
Diet			X
Activity	X		
Patient Care			X
Counselling			X
Medical			X
Security			X
Family Relations			X
Administration		X	
Transportation		X	
Extras	X		
Supplies	X		

1) **joint responsibility**: personal care and transportation (Rosehaven staff scored more in favour of institutional responsibility and relatives more in favour of family responsibility;

2) **institutional responsibility**: housekeeping, dietary, patient care, counselling, medical care, security, family relations and administration;

3) **family responsibility**: activities, extras and supplies.

The responses of Rosehaven staff identified the institution as having primary responsibility for care tasks while relatives assigned primary responsibility equally to both the joint and institutional categories. However the disagreement between the two groups was not strong; statistically significant differences were present for only 19 of the 100 tasks specified. Neither staff nor relatives saw the family as having primary responsibility for care; this is likely due to the technical nature of many care tasks, as well as the length and difficulty of care for the chronically mentally ill.

Most responses seemed to fall either in the institutional responsibility category or the joint responsibility category. Where there were disagreements, each group tended to assign tasks to itself; this tendency of each group to assign tasks to itself or to the joint responsibility category gives the impression that each is willing to take responsibility for care.

Analysis of the results showed that Rosehaven staff strongly identified technical tasks as being institutional responsibilities. Relatives generally did so as well, but indicated a desire to be more involved than staff felt they should be; staff tended to take over total care.

In most cases, significant discrepancies had to do with non-technical tasks. Achkewich concluded that "families by-in-large indicate a willingness to participate and claim responsibility for non-technical care tasks. Staff appear to insufficiently recognize the families' responsibility for non-technical tasks. They may in fact not communicate sufficient support to families to take responsibility for non-technical tasks, thus creating ambiguity and discouraging involvement. Families themselves

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may be reluctant or confused as to how they are able to stay involved, and without support, education and encouragement fade into the background."

While disagreements between staff and relatives on task division were not profound, with both assigning the majority of tasks to the institution, families seemed to want more involvement, while the institution seemed unsure about how to accommodate this under-utilized resource.

Since shared care is part of the philosophical shift to deinstitutionalization and community empowerment and may also help achieve the goal of quality care under budget restraints, Achkewich ends his study with seven recommendations for the Rosehaven Care Centre:

1) the concept of family involvement and care sharing should be made a part of Rosehaven's mission;

2) policy guidelines should be provided to staff for the implementation and promotion of family involvement;

3) family involvement activities should be coordinated through one department with staff professionally trained in working with staff, family and patients;

4) employees should be supplied with an orientation package explaining Rosehaven's philosophy and the importance of the family;

5) ongoing support groups should be established for staff, focusing on problems of delivering care to patients and families;

6) existing family support group workshops should be reviewed and revised to include a module on the role expectations of family and staff;

7) resources (money, manpower and facilities) should be allocated to ensure an effective family empowerment program.

Canadian Study of Aging and Memory

An important national study of dementia in the elderly was due to begin in October 1990. The Canadian Study of Aging and Memory (previously called The Canadian Collaborative Study of the Epidemiology of Dementias, including Alzheimer's Disease) has three aims: 1) to estimate the prevalence of dementia among Canadians age 65 years or older, 2) to determine risk factors for dementia of the Alzheimer type, and 3) to describe the current patterns of caring for demented patients in Canada, and to assess the burden that the process of caring places on family as well as professional caregivers.

The study is being sponsored by Health and Welfare Canada, and is projected to cost about $5,000,000 over two years. Several provinces, including Alberta, are funding local extensions to the study directed at answering questions of provincial interest.

Investigators from 17 universities across the country (including University of Alberta and University of Calgary) collaborated in the preparation of the study protocol and will oversee the conduct of the study, with University of Ottawa as coordinating centre. Information will be collected using survey sampling methods to ensure that the results of the study are national in scope and representative of the population — both residential and institutional.

The Canadian Study of Aging and Memory is one of the largest and most ambitious projects of its kind, and has the potential to produce findings of considerable importance to researchers and health planners. For additional information, the national coordinator is Barbara Helliwell at (613) 787-6447.

Recent Projects Approved by the Mental Health Division — Research and Ethics Review

Amantadine Hydrochloride Study
J. Sugars & S. Angus
South Region, Mental Health Division

Application of Olson's Circumplex Model to Sexually Abusive Families
C. Pittman
Calgary Region, Mental Health Division

Interpersonal Characteristics of Female Adolescent Suicide Attemptors
B. Bettridge
Calgary Region, Mental Health Division

Intergenerational Patterns of Rape Supportive Attitudes: Offender and Non-Offender Populations
L. Grimmer
Calgary Region, Mental Health Division

Long Term Effect of Sexual Assault on the Emotional, Social and Sexual Functioning of Adult Female Victims
M.J. Paulson
Northwest Region, Mental Health Division

Identifying Families for Studies of Genetic Linkage and Schizophrenia
D. Addington
Calgary Region, Mental Health Division

Common Influences in Alberta's Adolescent Suicides
R.J. Dyck
Head Office, Mental Health Division

An Evaluation of Suicide Episodes Before, During and Following Suicide Awareness Week, 1989-90
R.J. Dyck
Head Office, Mental Health Division

Recent Additions to the Mental Health (Head Office) Research Library

A Cost Benefit Analysis of Rosehaven Day Hospital: An Effective Alternative to Long-Term Institutionalization
M.A. Smith
Rosehaven Care Centre, August 1989

Responding to Natural Disasters: A Mental Health Perspective
D. Wollman
Edmonton Region, Mental Health Division 1989

Annual Mental Health Division Research Report. (Apr. l, 1988 – Mar. 31, 1989)
Research Unit
Head Office, Mental Health Division

Caring for People with HIV Infection/AIDS
Working Group
Alberta Health, May 1989

Tracking the Trends: Future Directions for Human Services in Edmonton
Community Trends Working Group, September 1989

Family Empowerment: Effectively Engaging Families in Care Sharing — The Ambiguity in Division of Tasks
S. Achkewich
Rosehaven Care Centre, 1989

Community Reactions to the Deinstitutionalization of Psychiatric Patients
B. Hall, D. Collins, M. Butt
Claresholm Care Centre, 1989

Social Problems, Westerly Trends, And Social Climate in Canada
A.H. Thompson, A. Howard
Head Office, Mental Health Division, September 1989

Assessment Package for Adults: Reference Guide
B. Hunter, L. Piche, et al
AADAC Assessment Task Group, 1990

Briefing Summary: Psychiatric Crisis Centre
S.E. Robertson
Edmonton Region, Mental Health Division, Jan 1990

Respectfully Yours: 50TH Year Commemoration — Raymond Care Centre
G. Heggie, et al
Raymond Care Centre, 1990

Foundations for the Future
Working Group on Child & Youth Mental Health Services, March 1990

The Chronically Mentally Ill in Fort Saskatchewan: A Needs Assessment Prepared for the Mental Health Advisory Committee
A. Mazo, S. Kiemitz
Fort Saskatchewan Mental Health Services, March 1990

Emotional Disturbance in a Sample of Children in the Care of Child Welfare: A Report Submitted to the Edmonton Region of Family and Social Services
A.H. Thompson
Head Office, Mental Health Division, January 1990

Research & Planning Retreat — A Summary
A.H. Thompson, P. Campbell, et al
Head Office, Mental Health Division, February 1990

An Overview of Mental Health Division
H. Borowski
Head Office, Mental Health Division, April 30 1990

Recent Publications by Mental Health Division Staff

Bland, R.C., Newman, S.C., Orn, H.T., *Health Care Utilization for Emotional Problems: Results from a Community Survey, Canadian Journal of Psychiatry*, Vol. 35, June 1990, pp. 397-400.

Bland, R.C., Newman, S.C., Dyck, R.J., Orn, H.T., *Prevalence of Psychiatric Disorders and Suicide Attempts in a Prison Population*, Canadian Journal of Psychiatry, Vol. 35, June 1990, pp 407-413.

RESEARCH & INFORMATION
MENTAL HEALTH NEWSLETTER

The Research and Information Newsletter is published periodically by the Mental Health Research Unit, to help department staff and other interested professional people keep abreast of current research and information related to mental health and other departmental programs.

The newsletter will present abstracts or summaries of selected relevant articles or papers produced by departmental staff. These will include new projects, published or unpublished papers, conference presentations, as well as research news.

If you feel you have an article which you think should be included in the newsletter, please submit a summary of your work (maximum 1000 words).

Acting Editor:
George Stebelsky

If you require additional copies of the newsletter, or know of any individual or group that would like to receive future issues, please call at 427-2816 or write to the Director of Mental Health Research and Evaluation, 4th Floor, Seventh Street Plaza, 10030 - 107 Street, Edmonton, Alberta, T5J 3E4.

Alberta HEALTH

Volume 6 Number 1 Fall/Winter 1991

RESEARCH & INFORMATION
MENTAL HEALTH NEWSLETTER

Suicide Awareness Weeks: The Outcomes

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T5J 3E4

The American Association of Suicidology has played an important role in fostering the development and implementation of Suicide Awareness Weeks throughout the United States and Canada. Following considerable pressure from a variety of sources, the Government of Alberta passed a motion in 1986 calling for the declaration of a provincial Suicide Awareness Week. Since that time, local, community suicide awareness/prevention weeks have been independently organized and implemented throughout the Province.

The impact of such a week, however, has yet to be determined. There is a substantial literature suggesting that publicizing suicides, especially in a romantic, glamorous, or sensationalized manner, may actually increase the likelihood of further suicides. Others have found no such effects. Yet others have suggested that suicide awareness education programs may, in fact, reduce the incidence of suicidal behaviour and have devoted a great deal of energy to developing and implementing such programs.

The Suicide Awareness Week concept is rooted within an educational framework. In other words, its purpose is to provide the general public with information about suicide, for example, how to recognize someone who is potentially suicidal, what to do, and where to go for assistance within the local community. Electronic and print media, public presentations, gatekeeper training, and distribution of educational brochures, pamphlets, and posters are some of the approaches used to deliver the message. Unfortunately, little, if any research has been devoted to examining the impact such weeks may have on suicidal behaviour.

The purpose of this study, therefore, was to examine the effect of the 1991 Suicide Awareness Week on the frequency of suicide-related calls to crisis lines as well as admissions to hospital emergency rooms for parasuicidal behaviour.

Method

Suicide Awareness Week was held in the Province of Alberta from March 4 – 10, 1991. Special suicide awareness emphasis was given in five secondary urban centres, ranging in population from 25,000 to 75,000, and two urban centres, each with a population of 600,000. The theme for the week was "Suicide affects all of us — Let's talk about it." At a provincial level, posters, brochures, and press releases were developed for distribution to all the centres. Centres developed and implemented activities appropriate to the needs of their own communities, in keeping with the provincial theme and using the distributed materials. These local activities included:

- television and radio talk shows;
- interviews with the print media;
- displays in libraries, hospitals, and shopping areas;
- development and distribution of wallet-sized cards with information about signs/symptoms of a potential suicide and local resources;
- training workshops in suicide intervention and suicide bereavement;
- presentations to educators, parents, and students.

In order to examine the net effect of the emphasis on suicidal behaviour during the week, hospitals in these communities and major crisis lines were asked to document all suicide-related episodes for a six-week period — two weeks before, the week of, and three weeks following Suicide Awareness Week. Crisis lines were asked to document the following information for each suicide-related call:

- date of call;
- whether the call was self or other-related;
- lethality;
- proposed method;
- gender of caller;
- age, gender, marital status;
- method;
- previous attempts;
- admission to a bed; and
- psychiatric consultation provided.

These data were tabulated and analyzed.

Results

Crisis Lines — All crisis lines participated in the study, reporting a total of 1,559 suicide-related calls for the six-week period. The majority of callers were female (66.5%), between 20 to 40 years of age,

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and calling for themselves (73.8%). Although the risk for suicide was rated as low for most callers (52.2%), overdose/poisoning (71.4%) was most often proposed as the method of choice for their suicide. Of the total number of calls, the highest number (275) occurred during the fourth week — the week following Suicide Awareness Week — declining to 205 calls in the last week.

Hospital Emergency Departments — Of the 14 hospitals contacted, 11 agreed to participate in the study. A total of 437 parasuicides were reported during the six-week period. The majority of parasuicides were female (55.6%), single, between the ages of 10 – 30, and presented with an overdose/poisoning (68.1%). More than half of those providing information (63.2%) reported past suicide attempts. About one-third of cases were given a psychiatric consult and 21.2% were admitted to hospital. Of the total number of parasuicides, the highest number (93) presented during Suicide Awareness Week, with a consistent decline in cases through the last week to a low of 41.

Discussion

Although the observed trends are not statistically significant, their direction is noteworthy. In both data sets, an increase in suicidal behaviour was detected either during Suicide Awareness Week (in the case of hospitals) or in the week following (in the case of crisis lines). One possible explanation of such an increase is that the Suicide Awareness Week may have achieved the desired effect of increasing awareness of available resources. For example, people reached out to crisis lines prior to making an attempt or, having made an attempt, they reached out to the hospital for help. Further research is required to examine this hypothesis further.

Alberta Mental Health
SUICIDE PREVENTION PROGRAM

The goals of the suicide prevention program are to reduce the incidence of suicide and self-destructive behaviours, and to reduce the impact of suicide on individuals, families, and communities. These goals are pursued through community outreach, education, training, and research.

The program philosophy is based on the following beliefs:

- by promoting the health of individuals, families and communities, the society as a whole can benefit;
- prevention of suicide is a societal and community responsibility;
- suicide prevention can best be accomplished through collaborative efforts with other organizations, agencies, and individuals.

1991 Highlights

- The third provincial Suicide Awareness Week was held in March, 1991. The theme "Suicide Affects All of Us: Let's Talk About It" was promoted by community agencies, volunteers, and media throughout the province. Special emphasis was given to survivors of suicide.
- Suicide Prevention Program development in smaller rural communities throughout the province has increased. In particular, Grande Cache and Grand Centre have expressed a great deal of concern about the suicide-related problems in their communities and are taking active steps to develop comprehensive Suicide Prevention Programs in these areas.
- Information requests to the Suicide Information and Education Centre stabilized this year. A total of 2,264 requests were answered and 30,191 actual documents delivered.
- The Suicide Prevention Training Program held 71 workshops this year. More than 11,000 Albertans have now been trained in suicide prevention. A Suicide Bereavement workshop for caregivers has been developed and is currently under field testing.
- The Suicide Prevention Training Program coordinated the development, testing, and distribution of the National Youth Suicide Awareness Presentation manual.
- A new position, Provincial Youth Suicide Prevention Coordinator, has been established.

Announcing...

Alberta Mental Health — Research Review, a newsletter published four times a year by Research and Evaluation, Mental Health Division of Alberta Health. Formerly *Research & Information,* our new newsletter emerges with a new audience, format, and expanded set of aims, namely:

- To provide a forum in which mental health research in Alberta is communicated to clinicians and researchers alike.
- To help bridge the gap between research and clinical practice.
- To foster research and publication within the Division of Mental Health.

In support of these goals, *Research Review* is distributed to Mental Health Division staff and to Senior Management of the Department of Health. Copies are also distributed to researchers and clinicians working in Alberta Hospitals, universities, and mental health-related facilities.

Forthcoming issues will feature selected research projects and innovative programs in mental health areas throughout the Province. In addition, the column "Updates" will report on new and ongoing research projects at various locations in order to foster networking among health care professionals working in the mental health area.

In addition to articles on research projects and innovative programs, the newsletter also presents abstracts or summaries of selected relevant articles or papers. These include new projects, published and unpublished papers, conference presentations, and research news.

If you are interested in submitting an article to *Research Review*, please send your submission (maximum 1,000 words) to:

Dr. Susan D. Hawkeye, Editor
Research Review
Mental Health Division
10030 – 107 Street
Edmonton, Alberta T5J 3E4
Phone: 427-2816
Fax: 422-9681

Inquiries regarding submissions or requests to be placed on the mailing list should also be forwarded to the Editor.

Early Detection of Neuroleptic Medication Side Effects in a Mental Health Clinic Setting: Report of a Pilot Project

Terry Fauvel, MD, FRCP(C)
Consulting Psychiatrist, Calgary Mental Health Services

Introduction

Neuroleptic medications, also known as major tranquilizers or antipsychotics, include drugs such as chlorpromazine, trifluperazine, fluphenazine, and haloperidol. Evaluation of treatment with neuroleptics can be particularly problematic in a mental health clinic setting. There is the potential for medication side effects to go unnoticed when psychiatric consultants have indirect responsibility and infrequent contact with clients. This may lead to unnecessary discomfort to clients who themselves have forgotten what a medication-free state feels like, as well as increased biosocial stress, possible non-compliance, and potentially serious complications including, but not limited to, tardive dykinesia (TD).

Tardive dykinesia is a neurological disorder which results from dopaminergic overactivity in the brain. It is characterized by tremors and other involuntary movements. Antipsychotic drugs can induce this disorder, which, despite discontinuance of the drug, is irreversible in some cases.

Moreover, TD has become an important medicolegal issue. A number of recent malpractice cases involving administration of neuroleptic medications were found in favour of the plaintiff. Malpractice suits were predicated on the following:

- inappropriate use of neuroleptics;
- lack of periodic evaluation of treatment;
- undiagnosed TD;
- lack of informed consent;
- lack of patient information upon early detection.

The medicolegal attention these and other cases received generated specific recommendations for professionals who care for patients on long-term neuroleptics. These recommendations apply equally to any treatment in any setting. As such, it is important for medical as well as non-medical therapists who look after this population to keep the following points in mind:

Long vs. Short-Term Use — Although the indications for neuroleptic use are narrowing, short-term use remains quite broad. Neuroleptics are often used as a chemical restraint tranquilizer when minor tranquilizers are contra-indicated and as an adjunct to medication with a slow onset of action. For long-term use, however, neuroleptics are coming to be accepted only for chronic schizophrenia, with a very few exceptions. Newer medications are superceding neuroleptics in the treatment of severe affective and anxiety disorders as there is concern that there is increased risk of tardive dyskinesia in these cases.

Informed Consent — It is important to educate clients about the risk factors involved with medication use and to work with them to determine the best course of action should complications develop.

Risk-Benefit — There is increased risk of TD with advancing age, in females, and, as mentioned, in the non-schizophrenic population. Clients are often unaware of their emerging dyskinesia, therefore formal objective clinical assessment is mandatory.

The risk-benefit equation should be discussed with the client, and documented in the chart along with reasons why neuroleptics are the drug of choice. The long-term use of neuroleptics for control or convenience is inappropriate.

"Least Effective" Dose — There needs to be an ongoing effort to lower doses, albeit slowly and carefully, in order to determine the smallest dose of medication to maintain remission. This may even include limiting the duration of treatment in selected cases.

Pilot Study

With these considerations in mind, a pilot study was conducted in the early part of 1991 at the Northwest Clinic in the Calgary region. In particular, the study addressed the need for periodic evaluation of treatment. The pilot study proposed, in brief, to provide for a more shared onus and improved coordination among client, therapist, and consulting physician in monitoring the use of neuroleptic medications.

Current policy places most of the onus for this task on the primary therapist. The current policy is apparently not well accepted because non-medical therapists are uncomfortable with the "medical" expectations this role places on them. They have additional concerns regarding their competence to evaluate a clinical condition which has serious medicolegal implications.

At the heart of this proposal is a medication checklist which clients fill out every three months. This screening instrument is designed to flag areas of concern which can be brought to the attention of the physician. The therapist's role is to oversee the whole process.

Medication Checklist

The following checklist was designed by listing a number of recognized side effects of neuroleptic medications. The list was then converted into a set of yes/no questions, avoiding medical jargon.

Side-effects can be classified. Most side effects of psychoactive medications are due to receptor blockade. Blockade at the dopamine receptor produces the therapeutic response, but also results in extrapyramidal side effects as well as endocrine and sexual dysfunction. Blockage at the muscarinic, histaminergic, and adrenergic receptors produces discrete clusters of side effects. Some side effects, such as allergic or toxic reactions, are not receptor mediated.

Side Effects

Antidopaminergic
EPS
Gynecomastia
Sexual dysfunction

Antimuscarinic
Blurred vision
Dry mouth
Tachycardia
Urinary retention
Constipation
Memory dysfunction
Decreased Sweating

Antihistaminergic
Sedation
Drowsiness
Weight gain

Antiadrenergic
Hypotension
Reflex Tachycardia

Certain side effects indicate specific areas of concern each requiring different management. The checklist allows these distinctions to be made, which thus guides the

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physician's management of each client.

Recommendations

The Northwest Clinic in the Calgary Region has been using this checklist since early 1991. The following represent our initial observations on the use of the medication checklist in client care:

- accepted by clients and therapists;
- simple to use; not time consuming;
- increased client awareness of their physical health;
- improved client/therapist/physician communication;
- 2 to 10 responses on average;
- responses stable when repeated;
- clients check items even if they antedate the medications;
- provides a record for medicolegal purposes;
- concerns more clearly identified for physician action.

The following recommendations are based on our initial observations and address the medicolegal and clinical issues in a mental health clinic setting such as ours:

1. Distribute information sheets on side effects;
2. Review medications with clients every three months;
3. Arrange a client-centered consultation with the prescribing AMHS physician every six months;
4. A formal involuntary movement assessment should be performed every six months.

Conference Announcements

June 29-July 2, 1992

Third International Rural Mental Health and Addictions Conference

Lethbridge, Alberta

Questions regarding conference registration, travel, and amenities to be found in the Lethbridge and the Chinook Country region should be directed to:
Conference Services
University of Lethbridge
4401 University Drive
Lethbridge, Alberta T1K 3M4

Present Surname: _____

Given Name(s): _____

Local File No: _____

Checklist for medication side effects

The following questions refer to problems seen sometimes with medications that you may be taking. Please make a check mark in the left hand column beside each problem that applies to you. If you are unsure if you have the problem, check it anyway. That way your therapist can discuss it with you.

Since starting your medication(s) have you noticed:

Check Here		
_____	A skin rash?	VII
_____	Blurred vision?	III
_____	Spasms or cramps in your muscles, neck or eyes?	IIb
_____	Swallowing difficulty?	IIa,c
_____	A tremor?	IIa
_____	Dizzy or unsteady on standing up?	IV
_____	Slurred speech?	IIa
_____	Dry skin or sweating less than usual?	III
_____	Tiredness or sleepiness?	I
_____	More constipation than usual?	III
_____	(Males only) Problems getting an erection?	III
_____	(Females only) New menstrual problems?	V
_____	(Males & Females) Sexual difficulties?	I
_____	Constant chewing, pouting or other facial movements you can't control?	IIc
_____	Feeling depressed all the time?	I
_____	Nausea, vomiting or diarrhea?	VI
_____	A tendency to burn in the sun easier?	VII
_____	Restlessness, as if you can't sit still?	IId
_____	(Males & Females) Breast enlargement, or even milk production?	V
_____	Stomach (abdominal) pains?	VI,IIc
_____	Excess sweating?	V
_____	Problems with concentration?	I
_____	Unexplained weight gain?	V
_____	A fast or pounding heart beat?	IV
_____	A stiff feeling in your arms or legs?	IIa
_____	Walking with no arm swing or stopped over?	IIa
_____	Excessive saliva in your mouth or drooling?	IIa
_____	Seeing halos around bright lights?	VI
_____	Feeling cold when others don't?	V
_____	Feeling slow in your movements?	IIa
_____	Excessive drinking? (more than 10 glasses of water a day?)	I
_____	Chest pains or breathlessness?	Ic,IV
_____	Any unusual movements or muscle twitches of your limbs or trunk?	IIc
_____	Your mouth is always dry?	III
_____	Difficulty starting to urinate?(pass your water)	III
_____	Seizures or sudden loss of consciousness?	VII

Thank you. Please bring this to your therapist.

Please do not write on this part

Date: _____

Reviewed by: _____

Comments: _____

_____

_____

Key: (Areas of Concern)

I. Psychobehavioral
II. CVS (a) Parkinsonism
(b) Dystonias
(c) Dyskinesias
(d) Akathesias
III. ANS
IV. CVS
V. Endocrine
VI. Other organ systems
VIII. Allergic, Toxic, Misc.

Guidelines

- Therapists should have clients complete the checklist every six months or more often as indicated, when neuroleptics are being prescribed by a clinic consultant.
- Consider having the checklist completed just prior to medication review by a consultant.
- Therapists review responses with clients, indicating "areas of concern."
- Have consultants review at their earliest convenience.
- Obtain baseline measurement if possible.
- Further evaluation by a consultant (AIMS, etc) may be appropriate in some cases.

Recent Projects Approved by the Mental Health Division — Research & Ethics Committee

- Client Satisfaction Survey
  A.H. Thompson, H.Z. Borowski & R.J. Dyck
  Head Office, Mental Health Division

- High Users of Health Care Study
  A.H. Thompson & H. Platt
  Head Office, Mental Health Division and Deputy Minister's Office, Alberta Health

- Sequential Approach to Social Skills Training with Schizophrenics
  D. Dobson
  Calgary Region, Mental Health Division

- Native Norming Project
  L. Grimmer
  Northeast Region, Mental Health Division

Recent Additions to the Mental Health (Head Office) Research Library

- Retrospective
  Mental Health Division 1988-89, May 1991

- Retrospective
  Mental Health Division 1989-90, June 1991

- Alcoholism in North America, Europe & Asia, (Eds)Helzer, Chanino & Chen
  R.C. Bland, S.C. Newman & H. Orn

- Estimating Morbidity Risk from Survey Data
  S.C. Newman, R.C. Bland
  American Journal of Epidemiology, 129: 430-438, 1989

- Schools as Places for Youth Suicide Prevention
  R.J. Dyck
  Head Office, Mental Health Division, 1989

- Research Methods in Psychiatry
  R.C. Bland
  Canadian Journal of Psychiatry 35: 614-615, 1990

- Promoting Mental Health
  R.C. Bland
  Head Office, Mental Health Division, May 1990

- The Efficiency of Two-Phase Designs in Prevalence Surveys of Mental Disorders
  S.C. Newman, R.C. Bland, R.C. Shrout
  Psychological Medicine 20: 183-193, 1990

- Twenty Years of General Hospital & Community Psychiatry in Calgary: A Mental Health Care Delivery System in Action
  G.M. McDougall, M. Entwistle
  Calgary Region, Mental Health Division, October 1990

- Mortality in a Cohort of Patients with Schizophrenia: A Record Linkage Study
  S.C. Newman, R.C. Bland
  Canadian Journal of Psychiatry (In Press)

- Phenylethylamine Metabolism in Tourette's Syndrome
  R.A. Bornstein, G.B. Baker, & S. Ashton
  Journal of Neuropsychiatry, Vol. 2, No. 4, Fall 1990

- What Motivates Volunteers at the Rosehaven Care Centre?
  C. Miluch, B. Olsen
  Rosehaven Care Centre, Mental Health Division, August 1990

- Social Problems in Canada: Westerly and Historical Trends
  A.H. Thompson & Y. Jin
  Head Office, Mental Health Division, March 1991

- Phenylethylaminergic Mechanisms in Attention-Deficit Disorder
  G.B. Baker, R.A. Bornstein, S. Ashton
  Biological Psychiatry 29: 15-22, 1991

- A Comprehensive & Practical Quality Assurance Program for Community Mental Health Services
  A.B. Eppel, C. Fuyarchuk, D. Phelps, A.T. Phelan
  Canadian Journal of Psychiatry, Vol. 36, March 1991

- Incidence of Post-Partum Depression in Rural East Central Alberta
  J.M. Clark, J. Folkins, L. Pell
  Central Region, Mental Health Division, Spring 1991

- Needs Assessment of Mental Health Services for Southeast Asian Immigrants: Selecting a More Adequate & Appropriate Program Model
  T. Tran, V. Smith
  Edmonton Region, Mental Health Division, Fall 1990

- Management of Psychological Trauma
  S. Robertson, R. Winnick
  Edmonton Region, Mental Health Division, March 1991

- No Show Study of the AATP Unit
  E. Daicar, R. Kokotilo
  Edmonton Region, Mental Health Division, August 1990

- An Evaluation of the Social Skills Programme
  D. Guch-Chichak, V. Hearn
  Edmonton Region, Mental Health Division, August 1990

- Assessing the Effectiveness of Family Support Programs in Reducing the Relapse Rates of Schizophrenia
  G. Van Oosten
  M.Sc. Thesis, University of Alberta, Spring 1991

- Insite: Referral Source Satisfaction Survey Results
  C.C. Fuyarchuk
  North East Region, Mental Health Division, December 1990

- The First Year at the New Raymond Care Centre
  S. Angus
  Raymond Extended Care Centre, Mental Health Division, Spring 1991

Grants Awarded Through the Alberta Mental Health Research Fund

The Alberta Mental Health Research Committee recommended grant approvals for the following projects in 1991/92:

Operating Grants

- McCallum, M. – Univ. of Alberta
  "Prediction of patient response to an evening hospital program"
- Kaplan, B. – Univ. of Calgary
  "Insulin-dependent diabetes mellitus and learning disabilities"
- Hodgins, R. – Univ. of Calgary
  "Substance abuse relapse in mood disorders"
- Addington, D. – Univ. of Calgary
  "Depression in schizophrenia"
- Conte, R. – Univ. of Calgary
  "The training of social competence in learning disabled children"

Special Competition Awards

- Acton, P. – Alta. Children's Hospital
  "Pretherapy training to reduce early dropouts in the treatment of maltreating parents"
- Addington, J. – Univ. of Calgary
  "Schizophrenic symptoms and information processing"
- Bakal, D. – Univ. of Calgary
  "Development of a physiologic monitoring system for the study of panic anxiety"
- Bland, R. – Univ. of Alberta
  "Attempted suicide: A Feasibility study"
- Devaraj, R. – Edmonton General Hospital
  "Memory function and mobility as a predictor of place of discharge and survival following geriatric rehabilitation"
- Costello, C. – Univ. of Calgary
  "Similarities and dissimilarities between community and clinic cases of psychopathology"
- Greenshaw, A. – Univ. of Alberta
  "Dopamine receptor changes induced by antidepressant drug treatment"
- Kaplan, B. – Univ. of Calgary
  "Continued development of a test of motor and postural skills for children with learning and/or motor problems"
- Laws, R. – Alberta Hospital Edmonton
  "Assessment of pedophiles using standardized slide stimuli and procedures: A multi-site study"
- Mash, R. – Univ. of Calgary
  "The relationship between vocal affect expression and behaviour in the patient-child interactions of hyperactive/oppositional children"
- Newman, S. – Univ. of Alberta
  "Family study of mental disorders"
- Oliphant, P. – Alta. Children's Hospital
  "Association between depression and attention deficit hyperactivity disorder"
- Piper, W. – Univ. of Alberta
  "Identification of effective therapist interventions in short-term individual psychotherapy"

Student Scholarships

- Hartley, J. – Univ. of Calgary
  "Schizotypy and limbic dysfunction"
- Todd, K. – Univ. of Alberta
  "Mechanisms of action of the antidepressant phenelzine"
- Sherry, R. – Univ. of Alberta
  "Analogues of tranylcypromine as potential antidepressants" (renewal)
- Aspeslet, L. – Univ. of Alberta
  "Importance of chirality and metabolism in the actions of the antidepressant fluoxetine"
- diLullo, S. – Univ. of Alberta
  "The role of dopamine and calcium channels in amphetamine induced environment-specific conditioning" (renewal)
- Goodnough, D. – Univ. of Alberta
  "Mechanisms of action of drugs used to treat refractory depression"

Research Unit Award

- Kaplan, B. – Univ. of Calgary
  "Developmentally disabled children and their Families"

RESEARCH & INFORMATION
MENTAL HEALTH NEWSLETTER

Editor:
Susan Hawkeye

If you require additional copies of the newsletter, or know of any individual or group that would like to receive future issues, please call at 427-2816 or write to the Director of Mental Health Research and Evaluation, 4th Floor, Seventh Street Plaza, 10030 - 107 Street, Edmonton, Alberta, T5J 3E4.

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